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ABSTRACT

ISFAR (Intensive Services to Families at Risk Project), a program designed to prevent foster care among children at risk for placement because of documented or suspected abuse or neglect, is described, and its effectiveness evaluated. ISFAR's staffing patterns, guiding philosophy of helping parents become more adequate in their interaction with their children, and positive organizational climate are discussed. Program operations are viewed in terms of intake and screening procedures, case assessment, parent's commitment, use of consensus as a decisionmaking tool, problem identification, case planning, individualized client services (including parenting education, home visits involving close friends and extended family, and group activities), case monitoring and evaluation, and followup. Project evaluation findings focus on system impact, client perceptions of services, and measures of individual and family functioning. Comparison with the county protective services revealed that ISFAR cases had lower rates of recidivism and resulted in fewer days in foster care. ISFAR cases were found to be more expensive, at least in short-term consideration. Process analysis underline the importance of support in casework decisionmaking. Characteristics of clients and of the services leading to successful outcomes are analyzed. More than half of the document is composed of appendixes: the actual project evaluation report, ISFAR entry criteria, a copy of a family interview instrument, a description of treatment groups, guidelines for staffing and restaffing, and descriptions of dissemination activities. (CL)

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INTENSIVE SERVICES TO FAMILIES AT-RISK PROJECT

Steven A. Rosenberg, Ph.D., Gay Angel McTate, M.S.W., and Cordelia C. Robinson, Ph.D.

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MEYER CHILDREN'S REHABILITATION INSTITUTE
HATTIE B. MUNROE PAVILION
UNIVERSITY OF NEBRASKA MEDICAL CENTER
and the
NEBRASKA DEPARTMENT OF PUBLIC WELFARE

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SUMMARY

The Nebraska Department of Public Welfare contracted with the University of Nebraska Medical Center to implement a three year demonstration program through Meyer Children's Rehabilitation Institute (MCRI). The MCRI program which was called the Intensive Services to Families at Risk Project (ISFAR) was one of seven research and demonstration projects funded by the Administration for Children, Youth and Families for prevention of the need to place children in foster care.

The object of ISFAR was to test the impact of an intensive services model as a method for the prevention of foster care and the improvement of child care practices in those families considered at risk for foster placement. ISFAR's service model was designed to provide families with comprehensive supportive services and parent training assistance.

The program approach was based on the assumption that a disproportionate number of at risk families would be characterized by low income, lack of child care knowledge and skill, poor physical and mental health, and a lack of social supports. The multi-faceted intervention strategy that was employed included the following three components: 1) environmental interventions to improve living conditions and life skills that interfered with parents performing child-rearing functions; 2) educational interventions to enhance parenting abilities, reduce parent-child conflicts, and facilitate child development; and 3) therapeutic interventions to strengthen relationships and increase self esteem.

The State Department of Public Welfare contracted with Urban and Rural Systems Associates to evaluate ISFAR. The results of the

evaluation show that ISFAR was more successful in preventing foster placement and eliminating problems that lead to the need for continued child protective services than the standard service approach. Equally important, however, are findings that indicate that a significant proportion of ISFAR's clients did not make substantial changes.

PROGRAM ENVIRONMENT

Background

Serious shortcomings in foster care systems across the nation have become evident during the past decade. In numerous cases children have been found to enter the foster care system inappropriately and to remain in care longer than necessary. Moreover, it is known that foster care can be disruptive of families, that it causes children to suffer stressful separations, and that it is expensive to implement and administer. The recognition of these problems led to a wide spread interest in developing service models that minimize the need to remove children from their families.

The Nebraska Department of Public Welfare, Division of Social Services' interest in the prevention of foster care is part of a continuing process of study and program development that began with the survey of foster care in Nebraska by the Nebraska Department of Public Welfare (1976) and which continued through the implementation of permanent planning for children in foster care and the development of the program described in this report.

The Intensive Services to Families at Risk Project (ISFAR) is the product of a cooperative effort by the Nebraska Department of Public Welfare and Meyer Children's Rehabilitation Institute at the University of Nebraska Medical Center to assist children who are at risk for removal from their families.

Characteristics of the Service Area

ISFAR operated in an urban setting. It was located in Omaha, Nebraska, in Douglas County, the most populous county and city in

Nebraska. Douglas County's population is estimated to be 395,000 persons, of which approximately 313,000 are individuals who reside within Omaha. The ethnic composition of Douglas County is primarily white; its largest minority group is black, which constitutes about 10 percent of the population, with smaller numbers of Mexican and native Americans.

Population Served

ISFAR clients were families with young children who were at risk for foster placement because abuse or neglect had occurred or was suspected. About 80 families were served by ISFAR during its 25 month service period. Douglas County Child Protective Services (DCPS) was the sole source of referrals to this project. Only a small number of the clients served were self-reported to Douglas County Protective Services.

PROGRAM MANAGEMENT

ISFAR was administered through Meyer Children's Rehabilitation Institute (MCRI) at the University of Nebraska Medical Center (UNMC). MCRI is a training institute for students from many disciplines. It provides services to developmentally disabled children and youth through age 21. It emphasizes early intervention, individualized attention to the needs of each child, maximum parental involvement, and uses an interdisciplinary team approach. ISFAR was physically located on the third floor of the Hattie B. Munroe Pavilion, which is adjacent to MCRI.

Personnel

The professional staff of ISFAR included the Project Director, the Family Worker Supervisor, the Family Workers, and Assessment Specialist. These individuals were all UNMC employees. A Social Service Clerk was provided by Douglas County; no financial support was contributed by ISFAR for this position. Two consultants, one for social work issues and one for psychiatric questions, were also available to project staff.

The Director of ISFAR was responsible for the administrative management of the project, including budget expenditures and personnel policy. The Director coordinated the writing of the final report of the project's activities. The Director maintained communications with counterparts at the Agency for Children, Youth and Families, the State Department of Public Welfare, Douglas County Child Protective Services, and the evaluators, Urban and Rural Systems Associates (URSA). The Director also assisted in the on-site evaluation activities. The Director was also responsible for making program and policy decisions, coordinating the multidisciplinary staffings, and developing service components. The Director was involved in the development and refinement of assessment methods and the development and modification of intervention procedures.

The Family Worker Supervisor was responsible for supervising the activities of the family workers and any practicum students working with the project. The Supervisor assigned cases and scheduled staffings of cases. This individual also provided and/or coordinated staff training. The Supervisor assisted in the development of new services within the project and in the creation or maintenance of linkages with community agencies in the Omaha area. Finally, the Supervisor provided direct services to a small caseload of families. Only families that had a child under seven years of age and in which immediate court action was not required were eligible for ISFAR services. The majority of families served were poor and had multiple problems. More detailed descriptions of the client population may be found in the Program Evaluation Section and in Appendix A, which contains the project evaluations done by URSA.

Philosophy Guiding Program Operations

The ISFAR project was guided by the principle that children generally do best in their own homes and that whenever possible, services should be directed toward maintaining children with their families. We assumed that parents who neglected or abused their children could be helped to become adequate parents. A central treatment belief was that each family has a unique structure, capacity, and needs, and consequently only a treatment approach tailored to the specific characteristics of each family would be successful. We also assumed that most parents were committed to their children and that an approach based on helping children by helping their parents could be successful.

The family workers provided casework to the clients. They assessed the problems of the family and the barriers to alleviating those difficulties. The also assessed the capacity of the families to make needed changes and identified the strengths in the families that would possibly allow these changes to occur. They assisted clients by motivating change, by teaching problem-solving skills and by providing guidance and support. They monitored child safety, health and hygiene, and provided opportunities for parent-child recreational activities. Finally, family workers were responsible for maintaining their clients' records.

The Assessment Specialist was responsible for administering a standard battery of diagnostic tests to target children and for presenting findings on ISFAR cases at staffings. Written reports of these evaluations were made for clients' records The project's Assessment Specialist consulted with workers prior to initial staffings and responded to workers' requests for evaluations of family members not initially tested or for appraisal of aspects of child or adult functioning not covered in the standard battery.

The social work consultant provided in-service training and consultation to the family workers and their supervisor on a regular basis during the first year of the project. The consultant also was extensively involved in the design of ISFAR during its period of initial development.

The psychiatric consultant attended alternate staffings and was available for evaluations of parents and children at the request of project staff.

A child development consultant was also available at the request of project staff. This consultant provided assistance in developing service plans for handicapped infants and preschoolers.

Secretarial support was also available to the project.

The social services clerk who was employed by DCPS processed paperwork for ISFAR cases and scheduled transportation for the clients. She verified that all essential documents were signed and kept track of renewal dates for services for each client. She was located and supervised at the DCPS office.

Organizational Milieu

The environment from which services are provided is thought to have an impact on the quality of these services. It certainly has an impact on worker satisfaction and may be important in limiting worker turnover. The ISFAR Project provided staff with a positive working environment. An important element of this work climate included the worker's involvement in the design of the project. They designed project forms, chose review periods, and created new program components. Beyond this, workers were given considerable autonomy in defining their work schedules to facilitate visits to families who could not be seen during the regular work day. They were also encouraged to explore outside training, reading, and contact with community resources. On-going and in-service training were regularly offered to the workers. These variations in duties were viewed as important, not just for the workers' growth, but also because these breaks allowed them to return to their work with families with a fresh outlook. Finally, ISFAR workers received higher salaries than most Douglas County child welfare workers.

A variety of administrative supports were used to enhance workers' capacities to assist their families. These included the availability of consultation from several disciplines, lower caseloads, the provision of time for case planning, close supervision, encouragement of case sharing, and immediate access to an emergency cash fund. The physical setting of the project was also a benefit. There was private space to interview families and areas for children to play. Moreover, personnel located at Hattie B. Munroe Pavilion consistently tried to help parents and children feel comfortable while visiting our offices.

Worker burn-out has received considerable attention in the child welfare literature. Burnout was not a major problem here. Turnover was low at ISFAR. It is likely that an environment where workers have some control over their schedules, rewards, and support is important when they are working with families who may not be appreciative and in situations in which they cannot exercise much control. Such an environment was reported by staff as a factor in producing ISFAR's low turnover rate.

PROGRAM OPERATIONS

Treatment Model

ISFAR's objective was to eliminate the need for removing children from their homes. This was to be accomplished both by reducing problems that interfered with the functioning of the family and by enhancing the child care skills of the children's parents. An additional treatment goal included providing children with access to programs and services that promoted their development.

It is difficult to provide a detailed characterization of ISFAR's treatment approach because the clients differed from one another and their problems and skill needs varied substantially. As a result no single treatment approach could be adopted for general use. What did unify ISFAR's treatment approach was an emphasis on solving problems of individual and family functioning and enhancing the quality of child care in those families. This problem solving approach involved an assessment of the household and its members--first, to identify areas regarding intervention and, second, to obtain information about the family that indicated possible avenues for treatment.

Workers used the assessment information to devise strategies for working with clients and to provide, either through ISFAR or other agencies, an array of resources and services that were sufficiently comprehensive to meet the needs of the families.

Finally, when a cooperative relationship between client and worker could be established, the basis was typically a mutually identified problem or task. Project staff worked with clients on these problems in ways that maximized the likelihood that other, possibly more serious or basic problems would also be alleviated.

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Intake and Screening Procedures

All clients were assigned on a random basis to ISFAR from the service caseload of Douglas County Child Protective Services (DCPS). When DCPS receives a referral, some initial screening is done by an intake worker. To eliminate inappropriate referrals, a home visit is then made by an intake worker who determines whether the allegations of abuse or neglect can be substantiated and whether the family should be offered services. Families requiring protective services are sent to a service worker by the DCPS intake supervisor. Where children are in immediate danger the case is also referred to the county attorney for possible removal and prosecution.

Cases that met ISFAR's entry criteria were referred by the intake supervisor to ISFAR. ISFAR cases were limited to families having at least one child under the age of seven. The child must not have been in immediate danger. Initially, the funding agency required that families having previous CPS contact be excluded from the project; this requirement was eliminated during the second year of operation. A detailed listing of ISFAR's entry criteria may be found in Appendix B.

When the case was received from intake, it was randomly assigned either to the project or DCPS as a Contrast case. Newly received ISFAR cases were reviewed by the Family Worker Supervisor, who assigned them to a worker for service. Cases designated as Contrast cases were turned over by the DCPS intake supervisor to one of the other three DCPS supervisors who assigned them to a DCPS worker for standard services. This procedure minimized the likelihood that DCPS service workers would be aware of a case's inclusion in the contrast group.

Case Assessment

The input information needed to devise a plan to enhance the care children received required some assessment of the children's environment, their current level of social and cognitive development, and the parents' skills as teachers and as disciplinarians. Each of these was assessed by the use of formal measures, by interviews, and through worker observations and impressions. The developmental level of at least one child in each household was obtained for children up to two-and-one-half years of age using the Bayley Scales of Infant Development (Bayley, 1969). The McCarthy Scales of Children's Abilities was used with children between two-and-one-half and eight years of age (McCarthy, 1972). Social development was assessed by worker observations and by parents' reports of child behavior on the Alpern-Boll Developmental Profile (1972).

The presence of child behavioral problems was often assessed, using worker observations and parents' responses on an inventory of common child behavior problems developed by Tams and Eyeberg (1976). This also provided indications of where deficits in parenting skills existed. Parenting skills were also assessed by observation. The household environment and the quality of care the child's parents provided were assessed through the use of the HOME Scale (Caldwell and Bradley, 1978) for children up to three years of age and with the Childhood Level of Living Scale (Polansky, Borgman and DeSaix,1972) for children between three and six years of age. These two measures assess aspects of the home that reflect parental ability to maintain an intellectually stimulating and emotionally nurturing environment. There are, however, substantial differences in what the two scales emphasize. The HOME

Scale was developed to indicate the intellectual stimulation and emotional climate; the Childhood Level of Living Scale considers the child's physical environment in considerable detail.

In addition to assessing parents' and children's abilities, it is also important to examine characteristics of the parent and family that are believed to be related to the parents' capacities to acquire and utilize new child care skills. The work of Tallman (1971) and Rosenberg (1977) has suggested that commitment, boundaries, consensus, and resources are variables that impact on the capacity to parent and the ability to improve parenting. A structured family interview (Appendix C) was used to assess each of these variables.

Commitment

The first of these variables can be defined as a willingness to actively pursue a goal. The level of commitment an individual brings to a goal related activity is determined by the rewards the individual associates with the goal and his expectancy of attaining the goal. For us, a parent's commitment to child care is of central importance. Parents will have low commitment to their children either when they do not value their children or what they can can do with their children, or when they do not expect to attain their child related goals. We assessed commitment to the child both through a structured interview and by observing parents' enjoyment of their children through conversation about child related goals and expectations and in their willingness to try to implement new ways of parenting their children. Parental commitment to their children was also assessed through the HOME Scale.

Resources

Families must have resources to exist. A family must have adequate housing and sufficient quantities of food and manpower to maintain itself and its members. In addition, the family must have the emotional and intellectual abilities and strengths needed to permit its continued functioning under stressful circumstances. We assessed each family's material resources by determining its income, housing, and access to transportation. In this connection we also considered parents' level of education, employment history, and job related skills. The Childhood Level of Living Scale was used to assess the condition of the family's material resources. Psychological strengths of family members were also assessed by history, emotional and intellectual abilities were evaluated through client's self-reports and worker observations, and if needed, formal intellectual and personality testing was done. Availability of support and child care assistance from neighbors, family, and friends was assessed during the structured interview.

Consensus

Family members must reach some stable arrangements with regard to their goals, the allocation of tasks, and the coordination of family activities--particularly child related tasks--if they are to be effective caregivers. Where there is a lack of consensus among parents and professionals over treatment goals, a child's care may be expected to suffer. We assessed consensus between spouses and between professionals as part of a standard interview as well as by less formal discussions.

Boundary Permeability

A family's external boundaries distinguish the family from the rest of the world. Boundaries within the family regulate interactions among the subgroups that compose the family and determine who is included in making decisions affecting family life. We formally assessed the openness of the family to information and materials from the outside world by interviewing the parents with questions concerning the extent to which the outside world entered their family and whether they felt their role had been taken over by people from outside the family. Boundaries were also assessed by observing a family's openness to new ideas and by determining which members were involved in decision making. Instances in which members were inappropriately involved in or excluded from decision making or where decision making had been turned over to outsiders would be noted as a problem in functioning. In such cases we considered the possibility of working with the family to change its boundaries during the program planning phase of our case management process.

Problem Identification

Clients' identification of their problems and descriptions of their situations provided essential information. This information was gathered through interviews with the family, by their reaction to the entry of protective services and by the nature of problems on which they indicated a willingness to work. No formal assessment of the validity of this framework for assessing protective service to families was done. However, workers felt it was a useful way of organizing information. A more detailed discussion of ISFAR's assessment procedures may be found elsewhere (Rosenberg, Robinson and McTate, 1980).

Case Planning

After the input data had been obtained, it was possible to formulate an intervention plan. The formal planning process began at a multidisciplinary staffing. The products of each staffing were a set of treatment goals and a corresponding set of strategies for attaining them.

Present at these meetings were family workers, who are social workers, the psychometrist, the Project Director, who is a clinical psychologist, a child psychiatry, consultant, and a DCPS worker who served as a liaison to ISFAR. At times, staff from other agencies attended to discuss cases on which we were collaborating.

The interventions to be used with families were developed in response to problems identified by parents or project staff during the assessment phase. The solutions to these problems became the goal of treatment. The goals were stated in operationalized terms so that we could define what changes were needed and know when the changes had occurred.

The intervention goals developed after a staffing could be grouped into short range and long range goals. Short range goals included the resolution of problems that required immediate attention and whenever possible, reflected the problems the family had identified. Longer range goals involved heightening the family's capacities to deal with problems and to care for its children. Strategies used to engage and intervene with a family were based on the strengths identified during assessment.

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Client Services

Services we provided to our clients were designed to meet their individual needs. Initially services were directed toward removing the major cause of danger to the child and towards solving the problems identified by the clients. Common to all initial problem solving was the use of interventions which also assisted in resolving more basic family problems.

Services were provided through home and office visits, through group activities, and through referrals to other agencies. Most contacts with families took place in their homes. The frequency of these visits was based on treatment requirements, the presence of a crisis, and on the family's wishes. Weekly contact was the norm. Initially home visits were necessary to monitor the safety of the children and to engage the clients. The home visits had the advantage of reducing clients' anxieties by permitting them the safety of their own homes and allowing the workers to assess the household environment and the clients' parenting skills. For example, on one initial visit to a young retarded mother and her infant the worker saw the mother feeding the child with a tablespoon in a rapid, shoveling manner. The young woman explained that she did this because her son needed to eat more, and went on to complain that the child was not cooperating. The worker suggested that she slow the pace on the feeding and use a smaller spoon. This led to substantial reduction in the frustration for both mother and child. This kind of practical on-the-spot suggestion was generally the most useful kind of parent training. We found that home visits lent themselves to these "seize the moment" interventions.

Parenting skills and techniques were an important focus during home visits. There were opportunities to discuss problems, to try out new techniques of discipline, to observe parents, and offer them immediate feedback. Often these sessions were quite active with both workers and clients working together to achieve desired parenting goals. In addition home visits almost always dealt with personal, family, and resource problems. At times these became so pressing that they tended to push aside activities geared to the improvement of parenting skill. As a result, workers had to plan home visits in order to be certain of including time for parent-child issues.

When appropriate, extended family and close friends were involved in the home visits. Contact with social network members was natural with home visits and was used to further treatment goals. In one instance a depressed mother related that her depression seemed to be due to her estrangement from her family. The family lived hours away and the connection between the young woman and her family appeared to have been broken. However, early in our involvement with this case, the client contacted her worker to ask for a Saturday visit. She wanted the worker's moral support when her grandparents, whom she had not seen for two years, came to visit. At her request the worker stayed for the first part of the visit. The worker conveyed to the grandparents her belief that this mother was concerned about the welfare of her child. Moreover, as a result of some pre-visit coaching from the worker, the client was able to deal with her grandparents' criticisms of her life style and her boyfriend without becoming defensive and hostile. The client felt that the visit was successful. After this visit her family began to pay her travel expense for visits to them. They were still unhappy with her life style but she and the child had been accepted back "into the fold." The realignment of the family had a dramatic effect on the young woman's self-esteem and her depression decreased as she started reaching out to friends and improving her environment. ISFAR's emphasis on making contacts with network members frequently resulted in a familiarity with family and friends of clients that was invaluable when out of home placements were needed.

Office visits were sometimes used as an alternative to home visits once the safety of the child no longer required frequent in-home monitoring. Office visits were used when the client needed encouragement about getting out of the house or when treatment goals could be more easily accomplished in the controlled setting of an office. Issues addressed in office visits were similar to those addressed in home visits but more often contained a counseling or formal instruction component. Office visits were obviously more time efficient for the workers. Before their case was closed almost all clients were being served, in part, through office visits.

A second component was services offered to clients in groups. Several types of groups were offered to ISFAR clients. One short-term group focused on teaching parents how to control their children's misbehavior using less punitive techniques than they had been using. A second group was offered to several young, isolated mothers. This group provided opportunities for socialization and helped them learn to solve problems that they faced in their daily lives. This group met for more than a year. For some mothers the casework done during the group was adequate for their needs and the group meetings replaced routine visits by a Family Worker.

Two groups were run for mothers who were mentally retarded. Each of these groups involved both mothers and their preschool aged children. One of the groups was a parent-child swim group, which was supervised by a swimming instructor. The group provided these parents and children with an opportunity for a positive interaction. Another group for these parents and children was structured to provide mothers with discussions of proper child care procedures, opportunities to practice appropriate parenting techniques with their own children, and a period of parent-child play.

Overall group activities were found to be useful component of the services ISFAR's clients received. A more detailed discussion of the group activities that were provided may be found in Appendix D.

In addition to providing direct services through individual and group contacts, the workers provided referrals and case management to the clients. Assistance in making referrals ranged from suggesting that a client seek help from a particular agency to accompanying a client for several appointments. The degree of involvement of the worker was based on the complexity of the service and the competencies of the client.

Almost all of ISFAR's cases were involved with other agencies as a result of our referral or because of prior contact with that agency. Often the ISFAR worker assumed a case management role and maintained contact with all persons who were involved in the case. The ISFAR worker frequently took on the role of scheduling meetings of the professionals involved with a family.

The agencies and professionals who worked with ISFAR clients included: resource agencies, such as public welfare departments; the local housing authority; food pantries; health services, such as Visiting Nurses, University clinics and private physicians. Mental health and family agencies were involved as were recreational facilities, legal services, and advocacy groups. We had no contractual arrangements with any of these organizations, but through informal relationships with their staff we were able to facilitate our clients' access to these services.

ISFAR had contractual arrangements for day care through the Nebraska Department of Public Welfare and worked closely with this service provider, not only in case planning but also in monitoring the physical condition and developmental status of the children.

ISFAR's affiliation with MCRI made consultation on child developmental problems quite accessible and facilitated the entry of clients' children into speech therapy, learning disabilities classrooms, and infant development services.

Several special resources were also available for ISFAR clients. The Hattie B. Munroe Board of Directors, which owns the building in which ISFAR was housed, provided generous donations of food and toys at Christmas time. The Board also hosted an annual Christmas party which many of the ISFAR client families attended. Members of a local church purchased clothing for 10 of ISFAR's families each year. Moreover, the church members often became involved as advocates for those families. Last, individual donations of such items as cribs, fans, and bicycles were obtained from individuals and businesses through the efforts of project staff.

We believe that comprehensive services involved a combination of a number of worker roles and therapeutic interventions. Most of ISFAR's clients had complex problems which could not be handled by any one agency. Consequently, the case management role was crucial to insure coordination of efforts and to prevent the fragmentation of those services the clients were receiving. The direct service provided by ISFAR workers was needed to elicit client involvement in the change process and to provide direct assistance in solving personal resource and child care problems.

Case Monitoring and Evaluation

Case monitoring was accomplished through supervision and multidisciplinary staffings. Supervision of the family workers occurred during weekly sessions, with group and individual sessions occurring on alternate weeks. Initially, individual supervision was a combination of traditional use of self-supervision, joint case planning, and the development of strategies for coping with difficult situations. As the workers become more experienced, time spent on case planning in individual supervision decreased, and these sessions become increasingly focused on addressing issues which hampered the workers' effectiveness.

The combination of individual and group supervision worked very well. Group supervision allowed for greater input into possible solutions for case problems, contributed to a sense of sharing the difficulties, undercut competitiveness among the workers, and allowed role playing of difficult situations. Individual supervision permitted workers needed opportunities for personal examination and personal support.

In general, the Supervisor took a more directive stand in case planning than is typical in social work supervision. This was necessitated by complex and sometimes immobilizing problems that were presented to the workers by their cases. Although it is widely held that such supervision leads toward dependency, we did not find this to be the case. As workers became more experienced, they developed considerable confidence and needed less direction.

Times when supervision appeared to be most helpful were at crisis points, when objectivity was threatened, when workers were feeling "burnt out," and in making major decisions where responsibility was best shared.

The value of providing workers with guidance and support through supervision is not readily traceable to more effective services for families. We know that it contributes to staff morale and we believe that it contributes to a climate in which creative ways are found to fit services to the needs of family members. We also think that it may be effective in reducing turnover.

All cases were also reviewed at multidisciplinary staffings. Staffings were held during the first month of work with the family, followed by re-staffings at three to four month intervals. At the initial staffing of each case the family worker presented the asessment information and a tentative beginning case plan. The other project members would discuss the plan, offer suggestions for improvements, help identify areas where additional information was needed, and assist the worker in identifying strategies which were most apt to be successful. At subsequent staffings the plan would be reviewed, progress on identified programs noted, and additional strategies suggested. These staffings were particularly useful in offering the insight of a different discipline and in identifying trends or groupings among the families we worked with. Outlines of the staffing and re-staffing plans may be found in Appendix E.

Case progress was also monitored through the formal re-evaluations of children and their parents. These re-evaluations were carried out by the Diagnostic Specialist and the family's worker by using assessment measures.

Termination of Services

Case closure occurred after four conditions were met: (1) the referral problem had been eliminated and the child was no longer at risk; (2) the family was no longer requesting services; (3) a support system now existed for the family; and (4) the family would seek professional assistance if the problem occurred again.

Termination was discussed with the family at an appropriate time prior to closing and was usually a mutual decision of the worker and the family members. Sometimes a family was referred to another agency as part of termination; when this happened, the worker stayed with the case until the transfer had been completed.

Follow-Up Services

No formal follow-up procedures were established. However, many of our former clients have contacted us periodically to ask questions or to inform us about changes in their lives. Where needed, continued assistance and monitoring of the child's care was provided by an agency to which the family was transferred. Two of our families required continued CPS services and were transferred back to Douglas County Child Protective Services.

PROJECT EVALUATION

Formal and process evaluation were conducted by URSA. Their report may be found in Appendix A. In addition, ISFAR staff also analyzed certain data and have formulated some additional findings.

The total client population was 83 ISFAR cases and 79 DCPS cases. The data used in the formal evaluation were derived from sub-samples of this client population. Difficulties in collecting data made it impossible to obtain complete data on all clients in the ISFAR and DCPS groups. A summary of major evaluation findings may be found in Table 1.

Population

The demographic characteristics of both the ISFAR group and the DCPS standard treatment group are similar. This suggests that the procedure of random assignment of cases was largely successful. The clients were predominantly white, with blacks being the only minority ethnic group to have substantial representation in this client population (Appendix A, Table 1). Data reported on fathers may not be reliable and were incompletely reported. The available data indicate no significant difference on marital status of clients although more fathers were reported for the ISFAR group (35) than for the DCPS group (25) (Appendix A, Table 1). This difference may result from a greater willingness for clients to tell ISFAR workers, who were not Department of Welfare employees, about the presence of men in the families. Fear of losing ADC benefits may have caused clients to be less candid with DCPS workers who were directly connected with the Department of Welfare.

TABLE 1

Summary of Evaluation Findings

I Comparison of ISFAR and DCPS services	
Client Acceptance of Services	
ISFAR clients were 20 percent more likely to report that they accepted services without feeling threatened than were DCPS clients.	$X^2=2.09$ not significant
Perceived Stress	
ISFAR clients reported a 10 percent greater reduction in stressful events than did DCPS clients.	no statistical test
Help Received	
ISFAR clients were more likely to perceive their workers as "very helpful" than were DCPS clients	$X^2=16.81$ statistically significant
Problem Solving	
a) Number of problems The average number of problems worked on was 33 percent greater for ISFAR than for DCPS clients.	no statistical test
b) Progress in solution of problems ISFAR and DCPS clients both reported making only moderate progress toward solving their problems	no statistical test
II Outcomes for ISFAR and DCPS clients	
Foster placements	
a) Average number of days in public foster care was 20 for ISFAR and 46 for DCPS	no statistical test
b) ISFAR placed children from one family into long-term foster care, DCPS placed children from six families into long-term care	no statistical test
c) ISFAR placed children from two families into short-term foster care DCPS placed children from one family into short-term care	no statistical test

Recidivism	
ISFAR clients had a somewhat lower rate of re-entry into protective services than DCPS clients	z=1.75 statistically significant
Services and Costs	
a) Day care ISFAR clients received substantially more day care than DCPS clients	t=3.09 statistically significant
Annual expenditures for day care for ISFAR clients were more than four times greater than DCPS day care costs	
b) Worker time ISFAR workers spent 10 percent more time in direct and phone contact with clients than DCPS workers. DCPS workers spent 10 percent more time on management than ISFAR workers.	no statistical test
III Home environment of ISFAR cases	
ISFAR cases showed improvement on the HOME Inventory	t=3.59 statistically significant

For both groups, mothers had a mean age of 24 years. They were typically unemployed single parents who did not graduate from high school and were living in a household with one child (Appendix A, Tables 2 and 3). Both groups had an average annual income of under $5,000. The families were mainly neglectful rather than abusive to their children. The severity of abuse or neglect generally did not require medical treatment (Appendix A, Table 1). At entry the ISFAR group was found to have fewer instances of moderate and serious abuse or neglect than the DCPS group (Appendix A, Table 1). In part this may reflect a tendency for ISFAR workers to see client problems as being less severe than DCPS workers.

Although family size tends to be small (one or two children), DCPS families had significantly more children than ISFAR families ($p<.01$). The average age of all children in a family was also slightly higher for the DCPS group although the difference was not significant (Appendix A, Table 3). Most notable of the target child characteristics was the high number of children in both groups who were born prematurely (Appendix A, Table 1).

Program Evaluation

The program evaluation data consists of:

1) system impact findings, including amounts of service provided, days in foster care, and re-referrals to DCPS or ISFAR;
2) clients' perceptions of the services they were provided;
3 measures of individual and family functioning.

System Impact

Children of ISFAR clients received more day care then did children in the DCPS group. In part, this difference is due to the fact that DCPS clients are limited to six months of day care per year for children whose parents are not working or going to school while ISFAR was not subject to this limitation. In addition, there was a basic philosophical difference in the two programs with regard to day care. DCPS used day care primarily to provide respite for mothers. Although ISFAR used day care for respite, much of the day care provided was used because it offered socially and developmentally more stimulating environments for the children than did their own homes. ISFAR staff believed that the use of day care to encourage child development was important for these young preschoolers. In addition, whenever possible they sought to use Head Start and public school programs for eligible preschool aged children.

ISFAR clients were kept in treatment approximately three months longer than DCPS clients. The average service period for ISFAR cases was 12.8 months while DCPS cases averaged 10 months of service. For DCPS cases, during the entire service period the cases were more likely than ISFAR cases to be closed and then reopened. For both groups the majority of clients were seen for total periods of greater than six months.

A time study of ISFAR and DCPS workers (Appendix A, Table 5) indicated that the percentages of time workers spent in their different activities were quite similar. Some interesting exceptions include the fact that DCPS workers spent about 20 percent of their time in either face-to-face or direct telephone contacts with clients while ISFAR workers spent about 30 percent of their time providing direct service to their clients. DCPS workers spent about ten percent more of their time doing case management than ISFAR workers. In part this difference reflects the different models of service that these two units utilized. DCPS, as do most protective service units, utilizes a case management coordination approach. This model does not emphasize the workers' role as a primary service provider. In contrast, ISFAR espoused placing the worker in the role of primary service provider.

ISFAR and DCPS also differed in the area of supervision. ISFAR workers, who received substantially more supervision than DCPS workers, spent between two and three hours a week in supervision, which was about an hour more supervision per week than DCPS workers received.

A major finding contained in the evaluation is that DCPS cases were much more likely to require reopening than ISFAR cases (Appendix A, Figure 1). In part this occurred because DCPS workers were encouraged to maintain cases for shorter periods than was ISFAR and to reopen these cases when a significant problem arose.

The finding that DCPS cases were more likely to be reopened was apparent in data that were collected in the Fall of 1980. To examine the differences between the two groups at a later date, ISFAR staff collected client data in January, 1981, six months after most ISFAR services had ceased and at a time when most cases were either closed or had been transferred to DCPS. This was also 20 months after new cases were no longer being accepted into either the ISFAR or the DCPS comparison groups. At this time 11 out of 83 ISFAR cases were found to be open and 16 out of 79 DCPS were open. Using a one-tailed test of significance of proportions, this difference was found to be statistically significant. ($p < .05$). Of these, five ISFAR cases and two DCPS cases had never been closed; eleven DCPS cases had been reopened, compared to nine ISFAR cases that had been reopened and were in service in DCPS. These findings indicate that after a substantial period of services, ISFAR cases were less likely than DCPS cases to be active with protective services either because they needed continued follow-up or because they had to be reopened. These findings also indicate that within the time frame indicated, each program may be expected to have about ten percent of their cases open because they have been re-referred.

The evaluation also indicated that DCPS cases had required substantially more public foster care than did ISFAR cases. This finding is at least partly the result of two differences between the programs. ISFAR workers placed more children with extended family and friends than did DCPS workers. Long-term network placements were made for children from six ISFAR families; of these 11 children three adoptions were arranged. In the remaining cases the foster parents were given the status of legal guardians. In all but one instance, these placements have remained intact.

Network placements have many advantages to recommend them; they require no public funds for foster care and are generally less traumatic for the children and their parents than placing children in long-term public foster care. Beyond this, it is likely that fewer ISFAR clients used any kind of foster care than DCPS clients. We believe that the greater client-worker contact and the more extensive use of day care obviated some of the child placements that would have otherwise occurred.

Costs

A total of 12 CPS-supervised children and seven ISFAR-supervised children received foster care, totalling $21,203 and $9,652, respectively. Estimated total savings in foster care costs by the ISFAR project just for the project period was therefore $11,551.*

The additional annual cost of protective services supervision for an additional 2.8 months of services per family was $33,970. This amount was based on the combined salaries of the ISFAR project staff in the last year of the project and not on other program costs. The amount was derived from subtracting the cost for 10 months of salaries (10 months being the average length of time CPS clients were served) from the cost of 12.8 months of salaries (12.8 months being the average length of time ISFAR clients were served). Since caseload sizes were approximately equal at CPS and ISFAR in the last year of the project, no adjustment was made for number of clients served. Projecting this cost over the 2½ years of the project's active period serving 80 client families, this represents an additional cost of $1,061.50 per family. This cost is inflated, however, since the ISFAR salaries represent a higher ratio of the Assessment Specialist's time and of administrative salaries than would normally be required under CPS supervision. It is also inflated because the caseload size during the initial period was quite small. This cost should also be offset by reductions in foster placement supervision and related expenses.

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*The Douglas County standard payment rate of $190 per month was used when exact rates were not available.

The estimated annual costs for Title XX services based on final project year estimates were $4,404.50 for ISFAR and $1,553 for CPS for transportation costs, or a difference of $2,851.50. Annual day care costs were estimated to be $57,832 for ISFAR and $12,763 for CPS, or a difference of $45,069. These two figures represent an additional cost of $47,920.50 annually. Since ISFAR served 51 families and DCPS, 42 families in the last year of the project, this represents an additional expense of $49.38 for transportation and $830.08 for day care, or a total of $879.46 per family. These costs do not, of course, include the unaccounted extra costs of mental health referrals and other non-Title XX services.

The only other significant cost that would be incurred by agencies attempting to duplicate the ISFAR intensive services model would be the cost of consultation from the Assessment Specialist and other health and development experts who would attend staffings. ISFAR spent $4,135 annually for this program component. For most public agencies a full-time assessment specialist would be feasible and more cost effective than consultation.

Client Satisfaction

Clients' reports obtained through structured Exit Interviews, (Appendix A) at the end of their service period indicated that ISFAR clients had more favorable perceptions of the services they received than did DCPS clients. Although not statistically significant, ISFAR clients tended to report more positive initial attitudes toward acceptance of services than DCPS clients (Appendix A, Table 6). ISFAR clients perceived their workers as substantially more helpful to them than did clients of DCPS workers ($p<.001$). In part this probably reflects the difference between the philosophies of ISFAR and DCPS, in that DCPS workers primarily function as case managers and do not function extensively as service providers, whereas ISFAR workers tend to see themselves in a service provider role.

Individual and Family Functioning

Clients' reports of the effects of the services they received indicate that ISFAR had a somewhat greater impact on clients' functioning then did DCPS. On the Exit Interviews clients were shown a list of stressor events and asked how many of these occurred during the year prior to their entry into protective services and how many occurred during the year they were receiving services. They reported 10 percent greater reduction in stressful life events than did DCPS clients (Appendix A, Table 8). ISFAR clients also reported that they worked on 33 percent more problems than their DCPS counterparts. Members of both groups generally reported only modest progress towards solving those problems (Appendix A, Table 7).

An analysis of pre-and post-intervention data collected on ISFAR clients using the Inventory of Home Stimulation (HOME) was done. The HOME is used with families who have a child under three years of age. It assesses several aspects of child care which are associated with the development of young children. Data collected using the HOME Inventory indicated an overall improvement of ISFAR clients. However, it is important to note that the quality of care children received did not improve in all cases. We found that the HOME scores of 30 percent of the families showed no change and about 20 percent of the families showed some deterioration.

Summary

These findings indicate that ISFAR cases were less likely to be reopened than DCPS cases and that ISFAR cases spent fewer days in foster care. The results indicate that, at least in the short run, ISFAR cases were more expensive than DCPS cases.

Although there was general improvement within both groups, clients reported only modest progress toward the elimination of their problems. Finally, information gathered on ISFAR clients indicates that their improvements were not uniform - some clients developed substantially greater child care skills than others.

PROCESS EVALUATION

The process analysis, which is based on case records and client and worker interviews, sheds additional light on the positive statements of clients that were found in the Exit Interviews. It also examines the differences between the ISFAR and DCPS units.

The results of the process evaluation indicate that the chief differences between ISFAR and DCPS seem to lie not in the area of frequency and type of services but in the conditions under which work was done. ISFAR workers had more time for their clients and received more support and direction in everyday decision making than did their counterparts at DCPS. ISFAR Family Workers carried fewer cases than DCPS workers. ISFAR caseloads ranged from 12-15 cases, while DCPS workers carried 17-20 cases. ISFAR staff, generally, were under less pressure than DCPS staff. In part this was a result of the entry criteria for this study, which excluded cases from the ISFAR and Contrast groups that were court involved at the time of entry into DCPS. As a result, ISFAR workers had fewer court cases than DCPS workers and ISFAR workers were freed from many of the time consuming activities that are part of working with court involved families. Moreover, ISFAR workers had fewer cases in which children were in immediate danger than DCPS workers whose caseloads were only partially comprised of Contrast cases.

The importance of support in casework decision-making cannot be underestimated when one is working with essentially involuntary and typically ungrateful clients who do not change rapidly. The worker's sense of responsibility where there is high risk can be burdensome. The socio-economic restrictions of low income families becomes depressing to the empathic worker who strives to be a change agent. Also, the feeling that one is invading a family's privacy by penetrating its barriers is distasteful to many workers.

Family Workers received both support and direction in their casework decision making. In general the supervision and consultation they received were more frequent and intense than that of DCPS workers. Just as work with multi-problem families requires a more structured, directive approach and persistent follow-through, supervision in ISFAR was characterized by structure, directiveness, and systematic review. Reviews allowed workers to assess the effect of their efforts and to modify their goals and strategies where needed. Periodic review permitted workers to ventilate feelings of frustration about slow or unchanging families, to adjust expectations where appropriate, and to persist with needed intervention rather then to withdraw prematurely.

The interdisciplinary team approach encouraged comprehensive assessment and shared decision making which led to creativity in problem solving and the development of change strategies. Decisions were made on the basis of thorough assessments which included worker observations, information elicited from the family, and formal diagnostic testing. Responsibility for decision making was shared with experts from other disciplines. Decision making skills were enhanced by the ongoing staff development inherent in the process of discussing alternative approaches to problem solving.

The reduced pressure and the extensive support system, helped to alleviate worker stress and anxiety, and enabled workers to make objective treatment decisions. These conditions facilitated the development of positive relationships with the clients served and enabled the worker to focus on family strengths and to avoid being overwhelmed by family dysfunction. Client-worker relationships were characterized by empathy and positive regard rather than the guarded cynicism and pessimism typical of "burnout." Workers tended to be strong advocates for their clients and were not easily daunted by the complexities and frustrations of the welfare system. Clients responded to the quality of involvement with trust and at times, gratitude. They viewed ISFAR Family Workers as less coercive than DCPS workers, and they felt they were treated as individuals of worth. One depressed mother stated emphatically that her Family Worker had treated her "like a person." The quality of the worker-client relationship was in many cases paralleled by an improvement in the quality of parent-child interaction and in an increase in the sensitivity of the parent to the child's needs.

Whereas the ISFAR project provided direct services of an educational, therapeutic type, particularly in the latter stages of the treatment process, DCPS tended to confine itself to service linkage and coordination and to delegate treatment activities to mental health professionals in the community. The latter approach may be cost ineffective, particularly with chronic cases, in that the time of mental health professionals is more costly than that of social service providers. The process evaluation indicates that ISFAR demonstrated that highly trained social workers can be effective in reaching multiproblem families. Moreover, the use of diagnostic testing and evaluation by mental health specialists was valuable in the early detection of handicaps and the development of early intervention strategies such as infant stimulation and specialized school placement.

The ISFAR project and DCPS followed similar criteria for the use of foster care. The ISFAR project tended not to use county funded foster care because of the difficulty of access for a non-welfare based program. In addition, the ISFAR project staff tended to counsel biologic parents toward voluntary relinquishment when permanent out-of-home care became necessary.

Many of the families who were served had such multi-faceted problems that highly specialized services were needed to engage and maintain them in treatment. The ISFAR project provided the blend of casework, educational, and therapeutic approaches needed by this high risk population of children and families.

Clinical Observations

The observations of ISFAR workers provide useful information about the differences between families who displayed substantial improvements and those who did not make significant progress toward the elimination of their child care problems.

As might be expected, ISFAR workers found that both surface and longer lasting changes were more readily obtained in families who displayed the most strengths and who had a history of effective functioning. Generally, the parents in these families have had success in obtaining and holding jobs and in their own education. In these families parenting problems usually arose after a major dislocation. These families tended to be referred for mild abuse. Typically they were committed to their children, were not completely immobilized by their situation, and could form a relationship with the worker. In these cases the major referral problems were often eliminated within a few months. These clients generally could be helped to identify problems and make the changes needed to insure adequate parenting.

The example of one family that was referred for abuse is typical. The father had received a strict upbringing. He had low self-esteem and some difficulty in making friends. He left school in the tenth grade but had completed a GED in the Army and since then had worked steadily to support his family. The mother was obese and mildly depressed. She was very dependent on extended family and friends. These parents had done an adequate job of providing care for their three boys until the father lost his job and began drinking heavily. The care of the children deteriorated. The oldest son developed school problems. Ultimately the family was referred for abusing their second child. These parents reacted with anger and embarrassment to CPS entry into their lives. However, they were able to identify some problems and make some important changes. By the time this case was closed, the care of the children had improved. The parents had learned new ways of coping effectively with the second son's behavior problems. The father was employed and no longer drinking. The mother had a part-time job and was less dependent upon others. Finally, the oldest son's school problems had ceased.

In another case a single parent had been referred for abusing her two-year-old child. This young woman had been raised in a strict but nurturing family. She had completed high school and some college. Shortly before the referral she had been divorced from her husband and in the process, had become estranged from her own family. Although she had a job as a secretary, she also worked an extra job at night to pay bills remaining from the marriage. In this case, the intervention included providing financial counseling, behavior management training, personal counseling, and assistance in helping resolve the conflicts with her extended family. After six months, this child was no longer at risk. These two families are representative of a group of families who made rapid and lasting improvements in their child care practices.

Unfortunately, not all families made substantial improvements in the care they provided their children. Families where lasting change came slowly, if at all, were usually not functioning well in any part of their lives. These families represented about 30 percent of our caseload. Typically they were referred for chronic neglect. Usually their problems were pervasive and they displayed a long standing inability to effectively cope with common life activities. Parents in these families seemed to have no expectation that life could be better. They often described events in their lives as a series of circumstances happening to them and over which they had no control.

One such family was referred for neglect. This family lived in a large house with no heat and no hot water. The father, who left school in the eighth grade, had been in jail for three years, and had worked only irregularly. At the time of the referral, he had been unemployed for three years and indicated that he was not seeking work because of a back injury. The mother had graduated from high school and had two months of a training program. Her family had not approved of the marriage. She worked part-time to support the family and was seriously depressed. At the time of the referral the children needed medical care, clothing, and supervision. Moreover, in addition to being unheated, the house was so dirty as to constitute a health hazard. This was the second period of service for this family, the previous services having effected little change.

We worked with this family for almost three years, and while some things improved as a result of our involvement, the worker's impression was that the changes would not be lasting. Despite the worker's efforts, the father remained unemployed. The mother remained depressed but would periodically seek mental health counseling. The conditions of the home improved, although there were still serious lapses. The children's medical and clothing needs were met and most of the time the house had heat and water. The most useful intervention was the provision of day care services for the children, from which they both benefitted greatly. This family had a positive relationship with the ISFAR worker and was able to make some changes. However, the parents never regarded their world as one they could act upon effectively. They continued to look to external causes and cures to their problems. The maintenance of the improvements that were made appeared unlikely.

Another case involved a single parent who was referred for neglecting and mildly abusing two preschool children. When the worker visited, she found the apartment to be tightly closed and dark. The mother was severely overweight and depressed. She had been in foster care as a child, had left school at 16 when she had her first baby, and had a series of unsatisfactory relationships with dependent men. She had no idea that anything could be different in her life and reacted to CPS entry with indifference. We worked with this young woman for two years with virtually no movement, other than temporarily eliminating the referral problem. Again, probably the most valuable service we performed for this family was the provision of day care services. This provided the children with some stimulation and the mother was able to form a somewhat positive relationship with the center director.

As we worked with families we identified some characteristics that enabled us to predict whether they were most apt to be short or long-term change families. The first of these characteristics was the families' reaction to CPS entry. Generally when parents were angry or relieved, they could be helped to resolve their problems. The families who displayed indifference to our entry often felt no control over their lives and were most difficult to engage in change. We found that the willingness of family members to identify problems which they were interested in solving was another useful indicator. If after four contacts, no problem had been identified then change tended to come very slowly, if at all. Finally, an additional predictor was the family's past history of problem-solving. A family in which the parents had experienced very few successes in the past was unlikely to make rapid progress.

CONCLUSIONS

ISFAR's main objective was to serve at risk for foster care families in ways that reduced the likelihood that they would require foster care by improving family functioning and the quality of care that children received. The results of this project indicate that ISFAR services were more effective than the standard services provided by DCPS. ISFAR cases required less public foster care than did DCPS cases. ISFAR cases were also less likely to be re-opened or to be continued beyond the end of the service period than the cases that received the standard services. Clients who received ISFAR services reported working on a greater number of problems than DCPS clients, although both groups reported only moderate progress toward solving those problems. ISFAR clients reported a greater reduction in stresses than did clients who received standard services.

ISFAR services differed from DCPS's services in a number of ways. ISFAR workers had fewer court cases and lower caseloads. ISFAR workers were under less pressure to terminate their cases and spent more time providing direct services to clients than DCPS staff. Overall, ISFAR clients received more day care than DCPS clients. Finally, ISFAR workers appear to have made greater use of family and friends to support clients in providing foster care than DCPS workers.

Comparisons of ISFAR and DCPS indicate that clients were somewhat more likely to benefit from ISFAR services than from the standard services. However, these results do not indicate what proportion of the clients actually improved. An examination of data on ISFAR clients indicated that although improvement tended to outweigh deterioration, substantial numbers of clients either did not change or regressed, at least on some indices of change. ISFAR staff found that high change and low change clients represent different groups of people with different life histories and outlooks.

ISFAR's services were more costly than DCPS services. However, not all of these costs would continue if the program were adopted by a public welfare agency. The cost effectiveness of this program would also be greater in states where foster care costs are higher. Finally, it is too early to tell the extent of the long-term savings that could be achieved by ISFAR program through reduction of foster care and case reopening.

DISSEMINATION ACTIVITIES

Dissemination of information about ISFAR has occurred at different points throughout the project. Presentations about ISFAR have taken place locally as well as at national and regional meetings. A paper on assessment was recently published and other papers are being written and will be submitted in the near future.

A number of professionals and child advocates have requested and been sent written information about ISFAR. These individuals as well as others will receive copies of this final report.

Training based on some of the information generated through ISFAR is being incorporated into the child welfare training that social work students receive at the University of Nebraska-Omaha and into the training given child welfare workers by the Nebraska Department of Public Welfare. A list of ISFAR dissemination activities may be found in Appendix F.

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Appendix A

Evaluation of the Intensive Services to Families At Risk Project Conducted by URSA

FINAL EVALUATION REPORT

INTENSIVE SERVICES TO FAMILIES AT RISK
(ISFAR) PROJECT

Meyer Children's Rehabilitation Institute
University of Nebraska Medical Center
Omaha, Nebraska

March 1981

Urban and Rural Systems Associates
San Francisco, California

ISFAR EVALUATION PROJECT STAFF

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FORMAL EVALUATION OF THE INTENSIVE SERVICES TO FAMILIES AT RISK (ISFAR) PROJECT

The evaluation of the ISFAR Project was conducted by Urban and Rural Systems Associates (URSA). The process evaluation was conducted by Diane Scarritt, MSW. The data analysis and final report were done by Judith Schiller, DSW. The ISFAR Project served clients from March 1978 until August 1980, or 2-1/2 years' time. The evaluation was designated to determine system impacts, such as foster care rates and rates of case re-openings and re-reports; client impacts based on an exit interview and on diagnostic measurements; a time study of project staff versus contrast-group staff; a cost analysis; and a process analysis. All analyses were possible except for the analysis of the effectiveness of the diagnostic measures as diagnostic and assessment tools. Because of constraints upon the assessment specialist created by the requirement that the Children's Protective Services (CPS) workers be blind to the contrast status of their clients and due to the natural resistance of clients, the CPS group was not tested in sufficient numbers to obtain statistically significant differences between the two groups. It was frequently difficult to determine whether reports had been substantiated or not, so case openings were used as the measures of recidivism and or prior CPS involvement.

Process Evaluation

The process analysis was based on case records and client and worker interviews. It sheds light on the positive reports of clients found in the exit interviews. It also examines the differences between the ISFAR and CPS units. (See Appendix A for complete analysis).

The results of the process evaluation indicate that the chief differences between services provided by ISFAR and those by Douglas County CPS seem to lie not in the area of frequency and type of services, but in the conditions under which casework decisions are made. Project workers were under somewhat less time pressure and had more available support and direction in everyday decision making. While they carried almost as many cases as CPS workers, the family workers were not pressured by the need to work with families whose children were in immediate danger or to obtain information for filing petitions or to be responsible for rehabilitating court-involved families.

The importance of support in casework decision-making cannot be underestimated when one is working with essentially involuntary and typically ungrateful clients who do not change rapidly. The worker's sense of responsibility where there is high risk can be burdensome. The socio-economic restrictions of low-income families become depressing to the empathic worker who strives to be a change agent. Also, the feeling one is invading a family's privacy by penetrating its barriers is distasteful to many workers.

Family workers received both support and direction in their casework decision-making. Their supervision, consultation and training were, in general, more frequent and intense than that of CPS workers. Just as work with multi-problem families requires a more structured, directive approach and persistent follow-through, supervision in the Family Project was characterized by structure, directiveness and systematic review. Reviews allowed workers to assess the effect of their intervention and to modify their goals and strategies where needed. Periodic review permitted workers to ventilate feelings of frustration about slow or unchanging families, to adjust expectations where appropriate, and to persist with needed intervention rather than to withdraw prematurely.

The interdisciplinary team approach encouraged comprehensive assessment and shared decision-making as well as creative problem-solving and developing strategies for change. Decisions were made on the basis of thorough assessment, including worker observation, information elicited from the family, and formal diagnostic testing. Responsiblity for decision-making was shared with experts from other disciplines Decision-making skills were enhanced by the on-going staff development inherent in the process of discussing alternative approaches to problem solving.

The reduced pressure and extensive support system provided helped to allevaiate worker stress and anxiety and enable workers to make objective therapeutic decisions. These conditions facilitated the development of positive relationships with the clients served and enabled the worker to focus on family strengths and to avoid being overwhelmed by family dysfunction. Client-worker relationships were characterized by empathy and positive regard rather than the guarded cynicism and pessimism typical of "burnout". Workers tended to be strong advocates for their clients and were not easily daunted by the complexities and frustrations of the welfare system. Clients responded to the quality of involvement with trust, and at times gratitude. They viewed family workers as less coercive than CPS workers and felt they were treated as individuals of worth. One depressed mother, embittered by her initial experience with CPS, stated emphatically the family worker had treated her "like a person". The quality of the worker-client relationship was, in many cases, paralleled by an improvement in the quality of parent-child interaction and in an increase in the sensitivity of the parent to the child's needs.

Whereas the ISFAR project provided direct services of an educational, therapeutic type, particularly in the latter stages of treatment, CPS tends to confine itself to the service linkage and coordination and to delegate intensive treatment to mental health professionals in the community. The latter approach may be cost ineffective, particularly with chronic cases, in that the time of mental health professionals is more costly than that of social service providers. The ISFAR project demonstrated that highly trained social workers can be quite effective in reaching multi-problem families. The use of diagnostic testing and evaluation by mental health specialists was valuable in the early detection of handicaps and the development of early intervention strategies such as infant stimulation and specialized school placement.

The ISFAR project and CPS followed similar criteria for the use of foster care. The ISFAR project tended not to use county-funded foster care because of the difficulty of access for a non-welfare based program. Also, the ISFAR project tended to counsel natural parents toward voluntary relinquishment when permanent planning for out-of-home care became necessary.

Many CPS families have such multi-faceted problems that highly specialized services are needed to engage and maintain them in treatment. The ISFAR project clearly provided such a blend of casework and educational and therapeutic approaches to benefit a high risk population of children and families.

Costs

A total of 12 CPS-supervised children and seven ISFAR-supervised children received foster care, totalling $21,203 and $9,652 respectively. Estimated total savings in foster care costs by the ISFAR project just for the project period was therefore $11,551.*

The additional annual cost of protective services supervision for an additional 2.8 months of services per family was $33,970. This amount was based on the combined salaries of the ISFAR project staff in the last year of the project, and not on other program costs. The amount was derived from subtracting the cost for 10 months of salaries (10 months being the average length of time CPS clients were served) from the cost of 12.8 months of salaries (12.8 months being the average length of time ISFAR clients were served). Since caseload sizes were approximately equal at CPS and ISFAR in the last year of the project, no adjustment was made for number of clients served. Projecting this cost over the 2-1/2 years of the project's active period serving 80 client families, this represents an additional cost of $1,061.50 per family. This cost is inflated however, since the ISFAR salaries represent a higher ratio of the assessment specialist's time and of administrative salaries than would normally be required under CPS supervision. It is also inflated because the caseload size during the startup period was smaller than would be expected. This cost should also be offset by reductions in foster placement supervision and related expenses.

The estimated annual costs for Title XX services based on final project year estimates were $4,404.50 for ISFAR and $1,553 for CPS for transportation costs, or a difference of $2,851.50. Annual day care costs were estimated at $57,832 for ISFAR and $12,763 for CPS, or a difference of $45,069.

These two figures represent an additional cost of $47,920.50 annually. Since ISFAR served 51 families and CPS, 42 families in the last year of the project, this represents an additional expense of $49.38 for transportation, and $830.08 for day care, or a total of $879.46 per family. These costs do not, of course, include the unaccounted extra costs of mental health referrals and other non-Title XX services, of which it is believed the ISFAR project may have made greater use.

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*The Douglas County standard payment rate of $190 per month was used when exact rates were not available.

The only other apparent, significant additional cost that would be incurred by agencies attempting to duplicate the ISFAR intensive services model would be the cost of consultation from the assessment specialist and other health and development experts who would attend staffings. ISFAR spent $4,135 annually for this program component. For most public agencies a full-time assessment specialist would be feasible and more cost effective than consultation.

The costs of an intensive services approach appear to far exceed those of traditional protective services. It is not possible to say for sure whether these costs would outweigh the eventual savings of foster care costs, which also include foster care supervision (not estimated above). Policies that require foster care to be short-term and temporary, as intended, will reduce the costs that have been reported in the past. As a long-term investment in families and children, intensive services might well prove to be a frugal policy.

Demographic Characteristics

In a preliminary analysis of subsamples of 51 families each, from the experimental (ISFAR) and contrast (CPS) groups, it appears that the method of random assignment of cases was basically successful. The children were predominantly white, with Blacks being the only other ethnic group with significant numbers. (See Table 1)

Data reported on fathers may not be reliable and are incompletely reported. However, the data available indicate that despite no significant difference in marital status (i.e., married versus not married or living with a partner), more fathers were reported for the ISFAR group. (See Table 2)

For both groups, mothers have a mean age of 24 years. They are most typically unemployed single parents who did not graduate from high school (See Table 2) and who are living in a household with one child (the target child). (See Table 3). Both groups have an estimated annual income of just under $5,000 and are about as likely to be receiving some income supplements as not. Marital status, ethnicity, and employment are factors most likely to affect source of the family's income. These families are mainly neglectful rather than abusive to their children (as reported on the American Humane Association form). Severity of abuse is generally mild. (See Table 1). At entry, the ISFAR group was found to have fewer instances of moderate or serious abuse or neglect than the group. ($X^2 = 2.98$, df = 1, $p \leq .05$).

TABLE 1

TARGET CHILD CHARACTERISTICS AT ENTRY

	ISFAR		CPS	
	N	%*	N	%*
Ethnicity				
Black	9	18	16	30
White	34	68	34	64
Other	7	14	3	6
	50		53	
Relationship to Father				
Natural Child	35	61	22	40
Stepchild	0	0	3	5
Adopted	0	0	1	2
No father reported	22	39	29	53
	57		55	
Special Characteristics				
Premature birth	10	23	11	30
Mental/Physical Handicap	4	9	3	8
Chronic Illness	3	7	1	3
None	26	60	22	59
	43		37	
Severity of Abuse/Neglect				
No Treatment	38	90	28	68
Moderate	4	10	10	24
Serious/Hospitalized	0	0	3	8
	42		41	

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* Figures are rounded and may not total 100%

TABLE 2
PARENT CHARACTERISTICS FOR ISFAR AND CPS

	ISFAR		CPS	
	N	%*	N	%*
Parent Characteristics				
Mother's Education				
Did not graduate High School	25	57	24	60
High School Graduate	19	43	16	40
	44		40	
Mother's Work Status				
Employed	11	24	10	24
Unemployed	35	76	31	76
	46		41	
Mother's Age				
15-19 years	13	28	9	19
20-29 years	24	52	31	66
30-39 years	8	17	6	13
Over 40	1	2	1	2
	46		47	
Marital Status				
Married	22	43	16	31
Never Married	18	35	19	37
Divorced/Separated	9	18	15	29
Widow/Other, not married	2	4	1	2
	51		51	
Father's Education				
Did not Graduate High School	13	55	9	56
High School Graduate	11	45	7	44
	24		16	
Father's Work Status				
Employed	21	84	19	79
Unemployed	7	16	5	21
	28		24	

* Figures are rounded and may not total 100%.

TABLE 3
FAMILY CHARACTERISTICS AT ENTRY

	ISFAR		CPS	
	N	%*	N	%*
Determination				
Abuse	9	18	9	20
Neglect	37	71	31	66
Abuse and Neglect	5	10	7	15
	51		47	
Number of Children in Family				
One	42	81	42	81
Two	5	10	4	8
Three	3	6	2	4
Four	0	0	2	4
Five	1	2	1	2
Six or more	0	0	1	2
	52		52	
Estimated Yearly Income				
$0 - 2,999	11	24	5	11
$3,000 - 4,999	14	30	22	50
$5,000 - 6,999	8	17	6	14
$7,000 - 8,999	6	13	4	9
$9,000 +	7	15	7	16
	46		44	
Income Supplement				
None	24	50	16	39
AFDC	20	42	20	49
Other public/private	4	8	5	12
	48		41	

* Figures are rounded and may not total 100%.

Although family size tends to be small (i.e., one or two children), CPS families had significantly more children ($\overline{X}_{ISFAR} = 1.29$, SD = .76, $\overline{X}_{CPS} = 1.44$, SD = 1.01: $p \leq .01$). The average age of ISFAR target children was 28 months and 37 months for CPS ($p \leq .09$). The average age of all children in a family was also slightly higher for the CPS group ($\overline{X}_{ISFAR} = 28.6$ months, $\overline{X}_{CPS} = 32$ months, $p \leq .09$). ISFAR families receiving some supplement were contrasted with those receiving none ($X^2 = 1.066$, df = 1, $p \leq .35$).

Most notable of the target child characteristics is the high number of children in both groups who were born prematurely. The mean for the ISFAR group was about 25 per cent, and for the CPS group, 30 per cent.

Foster Care

Of the 73 contrast families surveyed, eight had one or more children who began foster care following project entry. One of these placements was short-term and lasted less than a month. Six others were long-term and one was only in placement two months at project termination. In Nebraska, the county generally initiates foster placement and turns payment and supervision over to the state when the court determines that the placement shall continue for a time beyond one or two months. Long-term placements were found to last from five months to a maximum of 17 months at close of the project period. Short-term placements are generally emergency, voluntary placements which may or may not be court-ordered.

Of the 80 experimental families, only three had children who entered foster care. Though the numbers are too small to determine significance, they are in ISFAR's favor. Two of the ISFAR cases received short-term foster placement and only one received long-term care. This family had its parental rights eventually terminated. One CPS family relinquished children for adoption and none had parental rights terminated.

It is felt that these rates of foster care placement underestimate the true number of placements that occurred, especially in the CPS group. It was not possible to obtain accurate information on cases that had children placed by counties other than Douglas County, due to a changeover in the Nebrasks state computerized data collection system during the course of the project. Case records suggested that one more ISFAR family and four more CPS families may have received foster care.* The low numbers of foster placements are also attributable to stringent selection criteria in the first year of services which eliminated families with prior foster placements or prior CPS referrals, and to the normally low rates of foster placement in Douglas County.

Total days in foster care were 1551 for ISFAR and 3361 for CPS. For the entire sample of all families who received services, the average number of days in foster care was 20 for ISFAR families and 46 for CPS families.

It is important to note that these numbers do not reflect the informal placements that occurred with friends and relatives and were not subsidized by foster care payments. When this situation occurred, it was frequently the result of patient casework and was considered a positive outcome for the children involved. The ISFAR project considered itself highly successful in arranging informal placements with families. It is not known to what extent CPS used this alternative.

Recidivism and Length of Service

Seven ISFAR cases were re-opened for services following their initial project closing as opposed to 18 CPS cases. (See Table below). This difference is significant ($X^2 = 6.34$, df = 1, $p \leq .05$) and is not attributable to variations in time of entry since clients were assigned to groups on a random basis and the number of new cases entered were approximately equal in both groups for each year of the project.

	Re-opened	Not Re-opened	Total
ISFAR	7	69	76
CPS	18	55	73

ISFAR cases were kept in treatment approximately three months longer than CPS cases, averaging 12.6 months versus 9.6 months for CPS cases. These figures include the additional time families received services following re-openings during the project period. The 18 CPS cases that were re-opened averaged a total of 12.6 months of service during the project period. Nine of the 13 CPS cases that were carried up until the time of project closing were cases that had been re-opened. 26 ISFAR cases were carried until project termination.

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*The data reflects only publically-funded placements. No information was collected on whether placements were arranged by private or public agencies or through use of family or social networks. It is likely these case record reports of placements without public funding were informal arrangements made through family and social networks.

Though ISFAR had somewhat of an advantage in that more cases remained open at project closing and therefore had fewer chances of case re-openings, it is clear that ISFAR was more successful in preventing recidivism. While the length of service cannot be determined as the causal factor, these data suggest that chronic, multi-problem families would be better served by ongoing supportive casework until they had reached more independently improved levels of functioning.

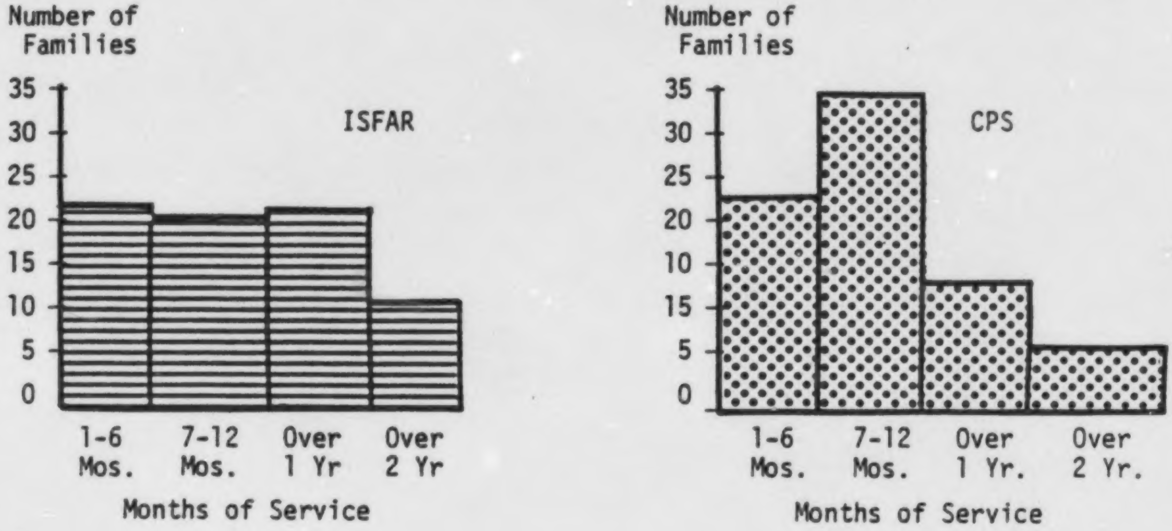
The chronic, repetitive nature of the difficulties of certain families is apparent upon examining histories of recidivism and foster care rates among the CPS cases. Prior to the project, 14 families had formerly received CPS supervision. Of these 14, seven were re-opened again after their initial project closing. Of the eight CPS cases that resulted in foster care, six had had a previous period of CPS supervision either prior to or within the project period. These six cases had also averaged ten months of supervision during the project period (the group average) prior to foster placement.

These data suggest that length of service period should be determined by the needs of the family. CPS workers were working under policy guidelines which encouraged termination of services after six months, whereas ISFAR workers were encouraged to terminate when families had achieved a reasonable level of improved functioning which they could be expected to sustain following termination.

When cases are re-opened it is usually because the problems in the family have again reached crisis proportions. They are usually re-opened because of substantiated instances of abuse and/or neglect. Because of the nature of the population being served, if foster placement is to be avoided and if these families are to provide safe and healthy environments for their children to grow in, public agencies will have to make long-term commitments to providing adequate support to them.

That is not to say that all families need long-term services. The pattern of service delivery is somewhat similar for both CPS and ISFAR clients. The graph below indicates the main difference being that ISFAR tended to see more families beyond one year whereas CPS saw the greatest number of cases for seven to 12 months.

DISPLAY
LENGTH OF SERVICES RECEIVED



CPS and the ISFAR Project served most of their clients for a year or less. Twice as many families in both groups were served from 13 months to two years as were served for more than two years. Thus services need not be interminable. Since clients were assigned to treatment groups on a random basis, the lower recidivism among ISFAR clients must be attributable to greater effectiveness of treatment and/or better discrimination of those families needing longer term treatment.

Diagnostic Measures

A battery of diagnostic measures was intended to assess outcome of clinical services and to be used as an intervening variable in the determination of foster care placement for client families. It was not possible to test for effects on foster care due to the small numbers of foster placements. Also, the contrast group of CPS families was uncooperative and there was not a sufficient number of their tests to compare treatment effectiveness. Another problem which contributed to the low number of retests was the use of measures limited to younger age groups. By the time many children were scheduled for retesting, they were too old for the test.

Nevertheless, based on the results for 47 ISFAR cases, the Caldwell Inventory of Home Stimulation appears capable of discriminating treatment effects. (See Table 4.) The Caldwell Inventory measures the adequacy of the home environment for children up to age three years. It samples certain aspects of the social, emotional, and cognitive support available to the young child in the home. For the ISFAR cases, Factor 1, emotional and verbal responsivity of mother; Factor 3, organization of the physical and temporal environment; and Factor 4, provision of appropriate play materials, showed significant improvement. Factor 2, avoidance of restriction and punishment by the parent; Factor 5, maternal involvement with child; and Factor 6, opportunities for variety in daily stimulation, showed only slight improvement. When all factors were combined, the ISFAR group had significantly improved overall. The mean time between tests and retest was nine months (SD = 3.9).

The Caldwell test results indicate that the ISFAR Project's emphasis on working directly with the parent-child relationship was largely successful in changing maternal behavior, especially in enhancing the mother's responsiveness and appropriateness.

The Bayley Scales of Infant Development are designed to measure both mental and psychomotor development of infants up to age 30 months. Only 11 Bayley retests were obtained for ISFAR cases. The average initial score was 91. The average test-retest interval, based on exact data for 9 cases, was 7.6 months. These 11 cases showed an average gain in developmental quotient of 5.6 points.

TABLE 4
IMPROVEMENT ON HOME INVENTORY FOR ISFAR CASES

	Mean Score Pre-Intervention[a]	Mean Score Post-Intervention	t-value
Factor 1	8.13	9.25	3.43***
Factor 2	4.34	4.98	1.97
Factor 3	4.19	4.98	3.33***
Factor 4	5.56	7.03	3.91***
Factor 5	2.95	3.36	1.39
Factor 6	3.13	3.24	.74
Sum	28.3	32.85	3.59***

* p .05 Two-tailed test
**p .01 Two-tailed test
***p .001 Two-tailed test

a. Scores were based on the ratio of number of yest responses to the number of total items minus the number of missing values. Maximum possible scores for Factors 1-6 are 11, 8, 6, 9, 6, 5, respectively.

Ten retests of the Polansky Childhood Level of Living Scale, another measure of the preschool child's environment, showed an average of ten points improvement ($\overline{X}_1 = 49$, $\overline{X}_2 = 59$) on a 99-point scale.

Service to Clients

A time study was made in the final year of the project comparing the time allotted for various work activities by CPS and ISFAR supervisors and caseworkers. At CPS, one supervisor and eight caseworkers submitted one-week time samples. Two ISFAR workers submitted three weeks of time sampling each and their supervisor submitted one week. Since the ISFAR supervisor spent half her time as a family worker in the project, her reported time was doubled to reflect one full-time supervisor and one full-time worker. The other workers' times were averaged and weighted to reflect eight weeks of casework, i.e., a rough equivalence to time reported by CPS staff.

The percentages of time spent in the various activities were highly similar for both groups except for several notable exceptions. (See Table 5). CPS workers spent 21%, or about one-fifth of their time in either face-to-face or direct telephone contacts with clients, while ISFAR workers spent almost one-third, or 30% of their time in direct contact with clients. CPS workers spent 10% more time doing case management and recording. ISFAR caseworkers averaged 1-1/2 hours of supervision per week whereas CPS workers received one hour weekly. Though this represents a small difference in total work time, given the low morale at CPS (e.g., a very high turnover rate), such additional supports for workers could be highly important in sustaining their morale and level of professionalism.

An examination of a sampling of five months of Title XX services provided in the last year of the project revealed that ISFAR clients received a significantly greater amount of child day care than CPS clients ($t = -3.0945$, $df = 8$, $p \leq = .01$) based on monthly costs for all clients in either treatment group. Over the five months, CPS clients received $5,317.95 of day care services, or an average of $1,063 per month. ISFAR clients received $24,096.64 for five months, or $4,819 per month. Many more ISFAR clients received these services than CPS clients; CPS has a six-month limit on the day care that they can provide to a mother if she is neither a worker nor a student. ISFAR was not under the same constraint.

Table 5

Percentage of Time Spent in Casework Activities by CPS and ISFAR Workers & Supervisors[a]

	CPS %	ISFAR %
Agency/staff meetings, staffing	5	7
Case Management	23	13
Education/training	4	3
Supervisory Meeting	4[b]	7[b]
Case planning & development	7	6
Direct Services		
Face-to-face client contact	14	20
Collateral contacts	13	11
Telephone contacts	7	10
Vacation, travel time, sick leave	12	7
Forms	2	3
Reading	3	4
Other	6	9

a. Figures represent averages of 1-week samples of eight workers and one supervisor for CPS and three workers (adjusted to reflect eight workers' time) and one supervisor (adjusted for full-time) at ISFAR.

b. Caseworkers' time only.

ISFAR also provided a greater amount of another Title XX service, transportation. Though the difference was not significant, ISFAR clients received an average of $1,835 per month in transporation services, as opposed to $647 for CPS clients. Again many more ISFAR clients were served.

Exit Interview

A list of approximately 70 problems was presented to the primary parent in 33 ISFAR and 24 CPS households. (See Appendix B for Exit Interview). These clients were asked to indicate whether their worker had identified any of these as problems for this client.* The problems included the range of problems that are common to abusive/neglecting families. It was anticipated that ISFAR clients would be able to discriminate more problems that their workers had discussed. An intensive services approach should provide more opportunity for workers to delineate and to work on problems with families. In turn, if the program was effective, families should be less defensive and more willing to acknowledge family problems. This, in fact, was the case. ISFAR clients identified 309 problems, or an average of 9.36 problems per family, whereas CPS clients identified 150, or 6.25 client--a 3.2 ratio.

Clients were also asked whether they initially agreed with their worker's assessment that the client had this problem. Rates are approximately similar, 57% agreement with the worker for CPS clients versus 63% agreement for ISFAR clients.

The five most frequently noted problems among ISFAR clients were 1) lack of relief from child care, 2) lack of medical care, 3) mother's psychological health, 4) social isolation, and 5) mother's physical health. (See Table 6). These were followed closely by the child's misbehavior and temper tantrums. Of these problems, lack of relief from child care was far and away the most frequently cited problem and was noted by four-fifths of the ISFAR families. Of the problems cited by ISFAR clients, the highest rates of improvement were for mother's physical health ($\overline{X}$ = 4.4), mother's psychological problems ($\overline{X}$ = 4.4), and medical care ($\overline{X}$ = 4.6).

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*An item was counted as a problem if the worker had discussed it with the client on more than one occasion.

It is surprising that relief from child care is not rated higher on improvement because of the greater amount of Title XX child care provided to ISFAR clients. Relief from child care is also the most frequently cited problem among CPS clients but is only cited by half the respondents. It is clear from the Title XX expenditures and clients' reports that ISFAR workers placed great emphasis on this aspect of their clients' needs. However, at the time the exit interview was administered many families would have lost or anticipated losing day care services.

From similar improvement rates in health related problems it appears that Omaha had adequate health resources and both service systems found no difficulty in assisting their clients to obtain help. ISFAR appears to have been particularly helpful with mothers' psychological problems, housing problems, and children's misbehavior. As with the Caldwell findings, these clients' reports suggest ISFAR workers were successful in teaching mothers ways to cope with their problems. Though clients reported reduction in their children's misbehavior, the Caldwell results indicate parents did not improve in their own handling of discipline.

CPS clients noted their most frequently occurring problems as 1) lack of relief from child care, 2) financial, and 3) mothers' psychological condition. Of these, greatest improvement was noted for financial condition and child care. The small group that was socially isolated apparently benefitted from CPS services.

Clients were asked why they accepted CPS or ISFAR services. They could respond that 1) they felt threatened, or feared losing their children, 2) they felt threatened but also welcomed help, or 3) they welcomed help. The results were that more ISFAR clients welcomed help and more CPS clients felt some degree of threat which motivated them to accept services.

REASONS FOR ACCEPTING SERVICES

	ISFAR	CPS
Felt threatened	4	8
Felt threatened, but welcomed help	7	5
Welcomed help	19	10

TABLE 6

Most Frequent Problems and Clients' Perceptions of Improvement[a]

Problem	Frequency		Mean Improvement Rate	
	ISFAR[b]	CPS[c]	ISFAR[b]	CPS[c]
Housing	10	6	4.2	3.44
Mother's physical health	14	3	4.38	4.25
Financial/job	13	10	3.9	4.0
Mother's psychological health	14	8	4.42	3.71
Child's misbehavior	13	5	4.0	3.75
Relief from child care	27	12	3.8	4.1
Social isolation	14	6	3.9	4.29
High expectations of self	11	2	3.58	4.0
Medical care	16	7	4.6	4.42
Child's temper tantrums	13	2	3.33	4.0

a. Improvement was based on a 5-point scale from much worse (1) to much better (5).

b. N_{ISFAR} = 33 clients

c. N_{CPS} = 24 clients

To perform a chi-square test, the responses were dichotomized into "felt threatened," groups 1 and 2, and "welcomed help," group 3. Results were not significant ($X^2 = 2.09, p \leq .15$) but indicate a clear trend for ISFAR workers to be seen as help agents rather than intrusive, authority figures. This may be accounted for by the fact that the clients did not perceive family workers to be the same as CPS workers, despite being told by ISFAR workers that they had the same legal authority and responsibility as CPS workers and despite having gone through the same intake investigation by CPS. This is probably attributable to both 1) the fact that ISFAR was located at the university medical center and became associated with the center in the minds of clients, and to 2) the help-oriented approach of ISFAR family workers. CPS was subject to a great deal of worker turnover during the course of this project. Worker frustration and depression could have been transmitted to clients in ways that felt threatening and non-supportive.

ISFAR clients also felt more helped by their workers than CPS clients. When asked whether they felt their workers had been 1) little or no help, 2) somewhat helpful, or 3) very helpful, ISFAR clients overwhelmingly responded "very helpful." These responses were dichotomized into "low help" (responses 1 and 2) and "high help" (response 3) in order to perform a chi-square test. The number of "low help" responses were 5 for ISFAR and 17 for CPS; "high help" were 23 and 6, respectively. The results were highly significant ($X^2 = 16.18, p \leq .001$).

In order to better understand the ways in which clients were helped, the evaluator asked clients to indicate any services that were provided them. Day care, emergency needs, counseling (both by referral and with their worker), and transportation were clearly the most frequently utilized services by both groups of clients. However, ISFAR clients mentioned an average of one more service received per family ($\overline{X}$ ISFAR = 3.45, N = 33; $\overline{X}$ CPS = 2.46, N = 24). The largest difference was in ISFAR's greater use of day care and referrals for counseling and treatment.

ISFAR clients also reported a greater decrease in stressful events in the year they received services. Stressful events included a birth, hospitalization, a move, job loss, separation or divorce, etc. ISFAR clients reported an average of 3.7 stressful events in the year before services versus 2.8 in the year they received services. CPS clients reported 2.9 stressful events before and 2.5 in the year services were received.

Stressful Events

	Before				
	Stresses	$\bar{X}$	Stresses	$\bar{X}$	N
CPS	71	2.96	61	2.54	24
ISFAR	123	3.76	93	2.82	33

Conclusion

Most of the data indicate trends rather than clear differences between the experimental and contrast groups. However, these trends are consistently in the direction of favoring the experimental group of ISFAR clients.

The ISFAR project served clients longer and had significantly lower recidivism (i.e., case re-openings) and fewer families entering foster care. ISFAR clients cited more services received, particularly day care and counseling or treatment referrals. ISFAR workers reported more time spent in direct contact with clients and ISFAR clients indicated a greater decrease in stressful events in their lives following services than did CPS clients.

ISFAR clients reported greatest improvement in mother's psychological problems, housing problems, and children's misbehavior. CPS clients reported greatest improvement in child care and financial conditions. These differences reflect differences in program emphasis but underestimate the ISFAR project's use of day care referrals which far exceeded that of CPS.

Due to client resistance, especially on the part of CPS clients, it was not possible to obtain sufficient data to contrast the two groups on diagnostic measures. However, the Caldwell Home Inventory showed general improvement for ISFAR clients, and particular success on the scales of maternal responsivity, appropriateness of play materials, and organization of the home environment. Again, this reflects the emphasis of the ISFAR program.

It can be said then that the ISFAR project was able to show success in most of its program goals. It did decrease stress, family crisis, recidivism and potential for foster care in families with multiple and chronic problems to a greater extent than traditional services, and it did assist families in acquiring access to community resources.

The program components that seem to have been most important, as deduced from the time study and the process analysis, are the greater time family workers spent in direct contact with clients and the greater support and direction given for casework decision-making. This support was characterized by thorough client assessments, an interdisciplinary team approach that encouraged shared decision-making and creative problem-solving, ongoing case reviews, intensive supervision, etc. This supportive atmosphere for the worker in turn contributed to his/her greater empathy in work with clients and to an ability to focus on family strengths rather than to become overwhelmed by family dysfunction.

APPENDIX A

PROCESS ANALYSIS AND EVALUATION:
FAMILY PROJECT (ISFAR)

INTRODUCTION

The following process analysis and evaluation of the Nebraska ISFAR project or "the family project" is based on data collected during two site visits--a one week site visit in September 1978, six months after program services were initiated, and a two day visit in June 1980 toward the conclusion of the three-year project. The information gathered was from interviews with program staff, observation of formal and informal interaction among staff and between workers and clients, as well as from written materials such as proposals, reports and case records. In addition, staff from Douglas County Child Protective Services and the juvenile court interviewed.

The uniqueness of the family project was its focus on preventive and early intervention to preserve the family unit while protecting the child. The project developed a supportive organizational structure and a treatment strategy for strengthening family functioning that represented a significant improvement over existing child welfare services. In particular, the use of intensive supervision, consultation and training as well as a comprehensive multidisciplinary assessment process seemed to be associated with improved caseworker rapport with clients and increased positive parent-child interaction and stimulation.

The contents of the evaluation include the history and development of the program, the setting and organizational structure, interagency linkages, and training, supervision and staff development. Program operation is described in terms of case acquisition and assignment, initial contact and assessment, multidisciplinary staffing, case management and treatment process, case closing, record keeping and the community context. The summary and conclusions include successful and exemplary portions of the project, areas for improvement, and implications for replication by existing CPS programs.

The purpose of the project, as set forth in the original grant proposal, was to develop a preventive early intervention strategy and provide intensive socio-educational services in order to: 1) reduce the incidence of placement of children outside the home, 2) enhance the capacity of parents to provide adequate care for their children, 3) reduce the number of characteristics of the family's physical and social environment associated with possible foster care placement, and 4) enhance the child's social and cognitive development. Additionally, the plan was to develop diagnostic measures that would assist in identifying families likely to have children placed outside the home in order that supplemental services might be provided prior to serious deterioration in levels of child care.

The program's approach was based on the assumption that a disproportionate number of "at risk" families would be characterized by low income, lack of child care knowledge and skill, poor physical and mental health, and a lack of social support systems. A multi-faceted intervention strategy would be employed and would include 1) environmental interventions to improve conditions of life that interfered with parent's performing child-rearing functions and 2) educational and therapeutic interventions to enhance parenting abilities, reduce parent-child conflict, and facilitate child development.

The theoretical underpinnings of the model were based on Tallman's[2] conceptual framework for family functioning. He asserted that the prerequisites for the effective family functioning were commitment, consensus, resources, and permeable boundaries. In relation to child welfare, these essential factors may be translated as follows: 1) A family must have adequate phyiscal and emotional resources. Services would seek to alleviate physical and emotional exhaustion associated with illness, stress, financial need, and so on. 2) Parents must achieve consensus around child care goals, tasks, and activities. Services would seek to enhance the capacity of parents to resolve differences by negotiation and compromise. 3) A family must be able to seek help when needed and at the same time maintain the integrity of its boundaries. Services would seek to maintain the sense of control and autonomous functioning of the family unit. And finally, 4) Parents must evidence commitment to maintaining the children in the family and to facilitating their development. Services would utilize short-term contracting to engage parents in enhancing their child's physical, social, cognitive and emotional development.

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[2] Tallman, I. Family Problem Solving and Social Problems. In J. Aldon (Ed.) Family Problem Solving. Hinsdale, Ill.: Dryden Press, 1971.

BACKGROUND

History and Development of the Program

The program model was conceptualized by psychologists Steven Rosenberg and Cordelia Robinson, based on principles of intervention with parents of handicapped children set forth in Rosenberg's unpublished dissertation.[1] These principles were applied to the delivery of services to families whose children were at risk of being placed outside the natural home and into foster care with the belief that early preventive intervention could reduce the incidence and duration of foster care placement.

The need for such services had been established in a study of foster care conducted by the Nebraska Department of Public Welfare in 1976 and entitled, "Where Are The Children?" This study, initiated by the Governor's Task Force on Child Welfare, was concerned with permanent planning for children in foster care. The intention of the model program was to compliment the Nebraska Department of Public Welfare's permanent planning strategies by providing a full range of preventive services needed to keep children and their parents together and functioning as family units.

The Department of Public Welfare's interest in requesting a demonstration grant was to develop a practical system for preventing foster care placements and to determine how existing agency resources might be reallocated to make the provision of such services part of the on-going program. Existing county child protective services programs were constrained by a six-month statutory limit on services and caseloads of 20 or more families per worker. The objective of the project was to develop an effective early intervention model that would decrease the use of foster care and that could be replicated at the county level.

The Nebraska Department of Public Welfare contracted with the Univesity of Nebraska Medical Center for a three-year demonstration program to be sponsored by the C. Lewis Meyer Children's Rehabilitation Institute located within the Medical Center. MCRI was selected, in part, because it had in the past developed innovative model programs for later transfer to generic agencies. The MCRI program was one of seven research and demonstration projects funded by the Administration for Children, Youth and Families for prevention of foster care placement.

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[2] Rosenberg, S.A., Family and Parent Variables Affecting Outcomes of Parent Mediated Intervention. Unpublished dissertation, George Peabody College for Teachers, Nasville, Tennessee. August 1977.

The focus of services would be to strengthen parental capacity to care for the child as opposed to providing direct services only to the child. It was felt such "parent-mediated" intervention would be more effective than the traditional protective services approach with its strong focus on advocacy for the child's well-being. Parent education would be adapted to the learning style and child-rearing values of the parent, along such dimensions as autonomy and control, acceptance and rejection, firmness and premissiveness.

The original plan was to serve 45 families with children aged six and under in the home. The families would be referred by a variety of social service and community agencies for intensive socio-educational services for a duration of two years. The belief was that many aided and low-income families with chronic, multiple problems would be referred and that the children would be at risk for placement outside the family. It was also assumed that a number of these children might have previously undetected handicaps. Services would include home visiting by a family and child specialist, diagnostic assessment of the preschool children, group counseling for parents, and coordination of the range of services the family might need or be receiving. The treatment plan for a given family would be determined and reviewed by a multi-disciplinary team.

Program funding began in October, 1977. The start-up process was complete and services to families began in April, 1978. Program operation was terminated in September, 1980.

During the past two years shifts and changes in the program were made for the following reasons: 1) to increase the likelihood of obtaining results that might be generalizable elsewhere and that might prove useful to the public sector, and 2) to make research and practical considerations rather than refuting referrals directly from a variety of agencies as originally planned. All referrals were made through CPS who could certify families eligible for Title XX services regardless of income. Some community agencies that initially supported the project were unwilling to refer families under this plan due to the stigma connoted by CPS and the possibility that the family would be assigned to the standard treatment group and be approached in a traditional rather than innovative manner. Criteria for inclusion in the program were changed as follows. The upper age limit of the target child was extended to age seven to ensure a large enough population for research purposes. To approach the realities of service delivery in the public sectors, families evidencing a higher degree of risk were included in the program. Only children who were in immediate danger excluded. From September, 1978 cases where children had a prior history of foster care or where families had previously received CPS services were no longer excluded from the project. Caseload size was also raised. When the project was defined by the State Department of Public Welfare as a unit of CPS and written requests for authorization of services beyond six months were required, the length of time cases were held were in effect shortened from the original intent of two years duration. The early plan to develop diagnostic testing measures that would identify families at risk of having children placed in foster care was abandoned as impractical when it became apparent that the population of children likely to enter foster care during the project's existence would be small. The primary purpose of using a battery of tests shifted to finding measures needed to describe and diagnose family functioning and formulate a treatment plan. Toward the end of the project, several families received only partial test batteries due to limited availability of the psychologist and the family worker's difficulty scheduling joint home visits. Due to time constraints, cases received testing at the beginning and end of treatment only, rather than at regular intervals as originally planned. At the request of program staff, the name of the project was changed from "Intensive Services to Families at Risk (ISFAR) to "The Family Project." It was thought this name would be more acceptable to the families served as well as less cumbersome. The project moved to a location that would permit increased privacy and reduced noise and distraction for workers. There was staff turnover at all levels.

Setting

The program is located in Omaha, Nebraska, in Douglas County, the most populous city and county in the state. According to a statewide survey in March, 1977, an estimated 4,00 families with preschool children receive Aid to Families with Dependent Children in Douglas County. The ethnic population of the county is primarily white. The largest minority group is black (about 13 percent of the population), with smaller Mexican American, Native American, and other populations.

The project is housed in an educational facility, the MCRI, on the campus of a large medical facility, the University of Nebraska Medical Center. MCRI is a training institute for students from many disciplines. It provides developmental disability services to children and youth up to the age of 21. It emphasizes early intervention, individualized attention to the needs of each child, and maximum parental involvement and uses an interdisciplinary team approach.

The Family Project was housed in a three-story brick building, the Hattie B. Munroe Pavilion, that also contained the Infant Development Program. Located on the same floor were numerous classrooms for working with handicapped children. Children, parents, and therapists were seen coming and going throughout the day. The project moved from a large room with partitioned work spaces to several offices shared by no more than two staff members. A separate room was available for interviewing. Sunlight, plants, and modern office furniture contributed to the pleasant, professional atmosphere. Project hours were from 8:00 am to 5:00 pm; however, flexible hours were utilized to enable services to families in the evening when necessary.

ORGANIZATIONAL STRUCTURE

Staffing Patterns

The personnel consisted of a full-time Project Director, a part-time Diagnostic Assessment Specialist, a full-time supervising family worker, two full-time and one part-time family workers, and a full-time secretary. In addition, the project included a variety of part-time consultants, a clinical social worker, a child psychologist, and developmental psychologists. Graduate social work students spent practicum time in the project and several graduate students were hired to carry-out specific research related tasks. During the final year of operation, a part-time social worker was hired to work on information dissemination.

The Project Director, Steven Rosenberg, PhD, was available on-site on a full-time basis but budgeted to the program less than full time. He was responsible for the administrative management and the overall direction of the project. He was responsible for the budget, expenditures, and personnel policy. He wrote progress reports on project activities and maintained communication with the ACYF, the State Department of Public Welfare, Douglas County CPS, and evaluators. He was responsible for making program and policy decisions, developing service components, coordinating the multidisciplinary staffings and supervising on-site evaluation activities. He was involved in the development and refinement of assessment procedures and intervention strategies. He provided a limited amount of direct services. His background included experience in structural family therapy and behavioral problem solving.

The supervising family worker, Gay Angel, MSW, ACSW, was responsible for supervision of the family workers and any social work graduate student assigned to the project.

She assigned cases and scheduled them for staffing. She, herself, carried a reduced caseload. She was responsible for developing and coordinating in-service training, for serving as a liaison to other service agencies and community groups in Douglas County, for assisting in the development of new services within the project, and for assuming administrative responsibilities as assigned by the Project Director. Her background experience included clinical work with children and families, work with parent groups, and teaching social work methods.

The family workers, Scotti Thralls, MSW, and Glen Fineman, MSW, were responsible for assessing family needs, providing direct services to families, and for referring them to other service providers where appropriate. They were responsible for daily casework decision-making and for preparing cases for initial and review staffings. They also developed and revised problem lists and maintained case records. Much of their time was spent making home visits. Their background experience included work with children and parents in a range of settings, including clinical, medical and recreational.

The Diagnostic Assessment Specialist, Kevin Cahill, MA, was responsible for administering a battery of diagnostic tests to both project and control group families and for presenting his findings at staffings. Written reports were made for case records. He consulted with the family workers prior to the initial staffing, and intermittently as requested by the workers. His background included extensive testing of children as well as psychotherapy with children and families. He began with the project at 28 hours per week. During the third year his time was reduced to 8 hours per week.

Bertine Loop, MSW, was hired in the final year of the project to gather and organize project materials, to identify targets for dissemination in Nebraska, and to develop a bibliography on the treatment of child abuse and neglect in multi-problem families.

The functions of the secretary, Doris Denny, included daily phone coverage, handling referrals from CPS at initial contact, and managing urgent calls from clients by locating the appropriate worker or herself arranging for concrete services.

The project employed two consultants. During the first year of the project the social work consultant, Nikki Zimmerman, ACSW, met with the family workers on a weekly basis to provide training and consultation. The psychiatric consultant, Ann Taylor, MD, participated in multi-disciplinary staffing on a regular basis and was available to see children for psychiatric evaluation.

The project was linked with the state and county departments of public welfare by liaison personnel who assisted at no cost to the project. The Project Director with the Division of Social Services, NDPW, served as contract officer and liaison between NDPW, The Family Project and the independent evaluator, URSA. The role of the NDPW Project Director was to assure proper flow of information, funding accountability, and planning for the integration of project findings into DPW's existing service delivery. Because of departmental changes and resignations, the liaison with the state changed several times.

Virginia Gross served as liaison with Douglas County CPS. She was accountable for mandated CPS services to the families in the project in the event of court referral. She followed these families by attending multi-disciplinary staffings on a regular basis. She also functioned as a protective services consultant and made home visits for the purpose of joint assessment.

John Weeks, who coordinated and supervised CPS intake investigations, was responsible for referring eligible families to the project. Gene Mallory, Unit Manager for CPS facilitated flow of information between Douglas County Social Services and the project.

Finally, a clerk with CPS, Laura Long, provided for authorization and documentation of Title XX services (both direct and purchased) for project families.

During the first year the project also had an Advisory Committee. At the outset it met three times on a quarterly basis. Its task was to plan for the dissemination of information about the project and for the incorporation of successful aspects of the demonstration model into existing welfare services. It was to serve as a vehicle for developing working relationships and increased coopration and coordination among various agencies serving the identified population. The committee consisted of 12 representatives from community and social service agencies. Its role was future-oriented and the lack of immediate goals mady have contributed to loss of interest. Project staff eventually fulfilled its tasks. The committee may be reconvened in the final stage of the project for dissemination purposes.

Interagency Linkage

Coordination with other service agencies and community groups occurred at both formal and informal levels. The Project Director provided administrative linkage with MCRI and served on the Head Start Health Services Advisory Committee. The supervising family worker served on a range of committeess, including a statewide advisory committee on child abuse, the local child abuse council, a coalition-network for treatment of incest, and a task force for the development of a crisis nursery. The supervisor also consulted in the development of planning grants for comprehensive emergency services and for a child welfare training program at the University of Nebraska Omaha School of Social Work.

Coordination with other service agencies also occurred during pre-service training and on an on-going basis for the purpose of case collaboration.

Staff Development Training and Supervision

During the first two months of project operation, the family workers received 80 hours of intensive training by both project staff and outside experts. Areas covered included child development, behavior management, introduction to psychological testing and assessment procedures, identification and treatment of child abuse and neglect, family dynamics, interview techniques, multi-disciplinary case management, use of community resources, and orientation to forms and record keeping. Staff from other community agencies, such as Douglas County Social Services, CPS, the Visiting Nurse Association, and the Eastern Nebraska Human Services Agency were included in training sessions on referral and case management.

During the first nine months of the project, the social work consultant provided training on a weekly basis to the family workers on such topics as family and group dynamics, use of self in the casework relationship, and specific therapeutic problems (e.g., working with single-parent families). This training was both didactic and experiential. Case material was presented for discussion. Additionally, for three months, in fall, 1978, the staff attended a class on family therapy at the University of Nebraska Omaha School of Social Work.

During the second year of the project, monthly in-service training was provided by the psychiatric and social work consultants and bu members of the staff. Areas covered included depression in children and adults, theories of child development, incest, alcoholism, divorce, blended families, working with hostile clients, when and how to make referrals, parent-child play sessions, group process, and the termination phase of treatment.

In addition, staff attended numerous conferences and workshops, including those sponsored by the Child Welfare League, the American Orthopsychiatric Association, the American Association for Psychiatric Services to Childre, the Philadelphia Child Guidance Clinic, and the Clearinghouse for Home-Based Service. Available to all staff was an informal library of books, journals and articles, both purchased by the project and donated by staff members, on child development, parenting, techniques of family therapy, and social work practice.

The family workers were supervised intensively on both an individual and group basis. Depending on their degree of experience with the project, workers met on a weekly or bimonthly basis with the supervising family worker, for one hour of indiviual supervision. These sessions were used primarily to discuss transference and counter-transference issues in treatment. Group supervision was scheduled on a bimonthly basis for two hours. Workers discussed problem solving and strategies for treatment and developed a sense of shared responsibility for cases. They had an opportunity to role play difficult situations and to receive feedback and support from co-workers. In addition, consultation with the supervisor or other staff members available on an informal basis as needed.

PROGRAM OPERATION

Case Acquisition and Assignment

Referrals originated from the CPS Intake Unit. Telephone or written referrals to CPS were screened by the CPS intake worker for appropriateness (e.g., malicious, repititious calls were screened out) and a field visit was scheduled within seven days of receiving the referral. The CPS worker determined whether the allegations of abuse or neglect were substantiated and whether the family would accept services on a voluntary basis. CPS services could be provided for 30 days without the family's consent. The worker might obtain the parent(s)' signature for Title XX services at this point and might also provide any urgent or requested services in order to facilitate the family's engagement in treatment. The case was then dictated and given to the CPS Intake Supervisor, John Weeks, for assignment to a continuing worker.

Following criteria developed by CPS and the Project Director, John Weeks, the CPS Intake Supervisor, screened all cases for possible referral to the Family Project. Only families whose children were in immediate danger, i.e., where removal from the home by police or filing of a court petition was indicated, were excluded from the project. Families having children age seven or younger, who were having problems caring for their children resulting in a finding of substantiated neglect or abuse, were eligible for the project. It was required that there be one parent or caregiver who had been responsible for the children from birth or for the past three years, and that this individual be available for continuing services. At the time of referral, the children might be physically or emotionally mistreated. No parental condition, such as substance abuse or physical or emotional disability, presented inclusion in the project. Although families in crisis were accepted, those needing short-term voluntary foster care (e.g., for two to three weeks) were not referred.

Upon receiving a referral from the CPS Intake Supervisor, the project secretary assigned the case to the project or CPS on the basis of a random number table. Cases were reviewed by the Project Director for appropriateness and consistency with project criteria and might be returned to CPS at this point if screening had been insufficient.

Once a case had been established as a CPS control case, the CPS Intake Supervisor referred it to one of the three CPS treatment units. No supervisor or case worker knew whether a case was a control case. The likelihood of a case worker learning of the control status of a case during the period of service delivery was relatively slight since the only contact Family Project had with the control cases was at the time of diagnostic testing. Further, the project was not identified by name to the control families seen by the diagnostic examiner. Since there were numerous studies being conducted by the University of Nebraska Medical Center with CPS families, the CPS worker could not have been certain which research group had contacted the family.

Cases were assigned to the family workers by their supervisors. Early in the project, cases were assigned simply by ratation. Subsequently, some attempt was made to match worker skills with family needs. This procedure became necessary with the inclusion of graduate students in service delivery.

Initial Contact and Assessment

Initial contact might be made by letter, phone or drop-in home visit, usually within a few days of case assignment. The family worker typically made home visits alone on an announced basis at a time mutually convenient for the family and worker. Evening appointments were offered to accommodate the single working parent or to ensure a father's participation. During the initial assessment period the worker sought to establish a relationship with the family. The worker clarified the family's percpetion of their problems and needs and collected necessary information for completion of forms, such as Title XX authorization and the Caldwell and Polansky inventories (measures of home environment).

The diagnostic testing of project families,which provided baseline data for research purposes and contributed to the formulation of a treatment plan, was introduced as a potentially beneficial service to families. The assessment specialist obtained the medical history of the children he was testing and administered the Bayley or McCarthy Scales and the Alpern-Boll Profile. The worker administered the Family Inventory and Locus of Control Questionnaire (measures of parental functioning). The Tams and Eyeberg Behavior Inventory was completed at the worker's option, often at a later point in time.

During the course of the project there were both delays in testing and a decrease in the number of individual children tested, in part due to the worker's belief that formal testing interferred with establishing a relationship with the family and in part due to the increasingly limited time and availability of the Diagnostic Assessment Specialist. Baseline data was typically collected after the family had been receiving services for 30 days. The loss of time in collecting baseline data was viewed as a trade-off to increase the validity of the measures by minimizing the family's denial of problems, which was typical at the beginning of services. Initially, the project planned to test all children under the age of seven in a given family. Due to the time limitations of the Assessment Specialist, it was decided to administer individual testing to approximately half of the children within this age range, including the target child in the family if one were identified. Selection of the specific children to be tested was at the worker's discretion and the family's request. During the third year of the project, the formal testing of individual children was done on a selective rather than a routine basis. Some of the testing was done by the MCRI's Infant Stimulation Program. If the worker, parent of referral source did not suspect a developmental, cognitive or emotional difficulty, no testing was done. This change was made in part due to the increasing time constraints and unavailability of the Assessment Specialist, and in part due to the increased comfort of the workers with making their own informal assessments. This change, however, resulted in loss of research data as well as delay in detecting handicaps and in setting individualized goals for children's developmental progress. It also resulted in case management being somewhat less directive at the outset.

Collection of baseline data was also delayed in CPS control cases. CPS asked that the Assessment Specialist not contact control families until the on-going CPS worker first made contact, usually within 30 days of case assignment. Due to the research requirement that the CPS workers be "blind" to the inclusion of control families in their caseloads, there were additional delays involved in checking records to determine whether a worker had made contact.

When collecting data on control cases, the Assessment Specialist was accompanied on home visits by a graduate student who functioned as the family worker, eliciting information and minimizing distractions by other children and adults during testing. Control families were told that they had been selected for a study of families serviced by CPS that was being conducted by the University of Nebraska Medical Center. They were told that the benefit to them for participating would be to receive developmental information about their children, that the results were confidential, and that they were under no obligation and would not be penalized in any way for choosing not to participate.

Testing conditions were at times less than ideal due to such factors as poor lighting, numerous distractions, and sleepy, irritable or otherwise inattentive subjects. The testing was usually done at a kitchen or dining room table with the mother holding the infant or close by in order to assist with a toddler. Mothers typically observed the process with intense interest in the child's performance. Immediate feedback was given both to control and project parents. Control families were encouraged to direct any request for services to their workers. In the event a serious disability were directed in a control child, the family might be referred to an appropriate agency for follow-up. CPS workers, however, were not informed of test results.

Multi-Disciplinary Staffings

Following the collection of basic information, the worker consulted with the supervisor on preparing the case for presentation at a staffing and on developing a problem list. The problem list was a set of objectives that served as the treatment plan. The supervisor usually scheduled the initial staffing within four to six weeks after the initial contact with the family.

Multi-disciplinary staffings were held on a weekly basis and attended by the entire project staff. The psychiatric consultant and the CPS liaison attended on a weekly basis initially and later on a bimonthly basis. Families were not included in the staffings. Workers from outside agencies were invited to attend for the purpose of collaboration. The standard format or "staffing plan" consisted of a joint presentation by the worker and Assessment Specialist. The worker provided identifying information, the reason for referral, a description of the physical environment, and a social history of each family member. The worker also provided a description of current family functioning based on observation and interview, and discussed such areas as commitment, resources, consensus, boundaries and child care skills. The Assessment Specialist presented the child's medical and developmental histories, the results of testing, and informal observations and impressions of family functioning. Parental expectations, which could be inferred from the Alpern-Boll, were compared with the reality of the child's functioning as indicated by the Bayley and McCarthy. The worker supplied descriptive and narrative information about the quality and content of interviews. The family's perception of problems and needs, services provided, and interventions made were summarized. The presentation was followed by the worker's statement of concern and delineation of areas needing further exploration. Reactions and opinions were shared freely by other staff and consultants. For instance, the psychiatric consultant might request clarification on medical information and parent-child interaction. The psychologist coordinating the staffing might request operational definitions of concepts used and translation of goals and to behavioral objectives and strategies. The Assessment Specialist might reiterate any areas of child development (physical, social, cognitive, emotional) that required further observation, evaluation, or intervention. Often the differing ideas resulted in cross-fertilization and innovative problem solving. For instance, a mother who lacked money for furniture and did not have a high chair fed her infant in its crib. As a result, the child had not developed a particular grasp reflex. The psychiatric consultant pointed out that the child lacked the experience of sitting up while eating and finger feeding and thus had not had an opportunity for stimulation and elaboration of grasping. The worker could then set a goal of assisting the mother in obtaining a high chair or infant seat in order to stimulate the child's physical development.

The focus of discussion was on ways of getting basic necessities met as a prerequisite for parent's learning about child care, on motivating parents to improve the level of care provided, and on enabling success or mastery experiences that would shape and maintain parental care giving.

A problem list was presented by the worker and approved by the Project Director. Additional suggestions might be made and support and praise offered to the worker. The group problem-solving process and the thoroughness and the warm tone of the staffings seemed to reflect the actual approach taken with the families. Written summaries of the staffing and reports of test findings were filed in case records.

Review staffings were originally to be scheduled every 60 days. Due to the likelihood of relatively minor change in such a short period of time, the reviews were scheduled at three to four month intervals. At this time the problem list and the family members responses to intervention were again presented by the worker. Those problems that had been resolved and speculations about the reasons for successful resolutions were discussed in an effort to determine what intervention had been effective and to clarify strategy. Unresoled and new problems were also discussed and the problem list revised. Priorities might change, new goals migh be added, strategies might be modified. Issues relevant to developing a positive worker-client relationship were also discussed.

Case Management and Treatment Process

The total number of families served during the project was approximately 80. At any given time the program had a capacity of 45 families. Caseload size ranged from 12 to 15 families, per worker. The average length of treatment was one year. Families received a combination of direct and indirect services.

Direct services consisted of home and office visits as well as phone contacts. Families were generally seen on a weekly basis but were seen as often as three to four times a week, or as infrequently as twice monthly. The worker's decision was based on whether a crisis existed, whether the case was so severe as to necessitate frequent monitoring, and whether the case was near closing. The family's wishes were also considered. Visits were primarily in the home. Office visits were used when increased structure was needed, such as when there were too many distractions in the home environment for effective interviewing. Group sessions were held outside the home. Transportation and child care were provided when necessary.

In general, the parents were seen either individually or conjointly, and the children seen only briefly. Extended family members were included at times. The process of interviewing included such interventions as active listening, asking questions and clarifying, suggesting, structuring parental behavior, and offering praise and emotional support. Teaching was done by helping parents anticipate and prepare for situations (e.g., by rehearsing), by shaping and by modeling. Education was provided in a variety of areas of home management and child care, including budgeting, eliminating environmental health hazards, nutrition, health care and behavior management. The worker's use of self in the case work relationship encouraged the client to express feelings. The focus was on problem solving.

Indirect services included making and following-up on referrals and coordinating the delivery of services. Through Title XX, services such as transportation, (e.g., cab fare for medical appointments and employment interviews), day care, and homemaker services were purchased. Referrals for financial aid included AFDC, GA, SSI, food stamps, surplus commodities, Mediaid, Crippled Children's Services, and the special energy programs. Referrals were made to churches and private charities, food orders, furniture, clothing, bedding and cribs. A contingency fund was available for emergency services and material needs in situations where other resources for payment did not exist. Workers were reimbursed for out-of-pocket loans to families, not exceeding $15. Families were referred for free or sliding-scale medical care if they lived in a target geographic area of Omaha. They were referred to the Visiting Nurses' Association for preventive health care, health education, and infant stimulation specialists who made home visits. Referrals were also made for emergency shelter, public housing, legal assistance, vocational rehabilitation, and education and training. Children at risk of developmental disability could be referred to the MCRI for infant stimulation, speech and language evaluation or physical therapy; the the East Nebraska Community Office for Retardation; and to the Boys Town Institute for Communication Disorders. Parents were referred to positive parenting groups offered by the Family Services Agency of Omaha and Council Bluff and to other parent education groups. Referrals were also made for individual, couples, and family therapy. It was the responsibility of the family worker to collaborate with other agencies providing services in order to coordinate service delivery to the family.

The project also offered several time-limited groups. The first group was offered for four months and focused on principles of behavior management, and alternative approaches to discipline. An educational group, offered for six to eight weeks, covered topics of child development, problem solving, developing a support system, and increasing assertiveness. A socialization group for mothers (most of whom were of below normal intelligence) began with an educational focus on child development and evolved into an experiential parent-child play group, during which mothers were directed to carry-out different tasks with their children that were designed to enhance mother-child interaction. A fathers' group was attempted, but terminated after six weeks due to lack of sustained interest. Techniques found useful in the parent groups were providing for socialization around food and use of activities such as swimming and outings.

A few cases were referred for voluntary foster care when no relatives or friends were available and the parent was in a psychiatric or financial crisis (e.g., in need of psychiatric hospitalization, evicted and unable to provide shelter), and when relatives were sabotaging parental care giving as part of on-going and severe family conflict. Police involvement was requested on one occasion where children were abandoned by the mother and left in the care of an inappropriate babysitter. Relative placements were facilitated in several situations. In one instance, a maternal grandmother became a legal guardian of the children of a mentally retarded teen-age mother. Another retarded mother, who could not manage her own affairs and evidenced little commitment to her child, was encouraged to place the children with a cousin. A mother who abandoned her infant at birth relinquished the child for placement with a paternal aunt. A mother how was depressed, suicidal, who was frequently incarcerated and suffered from substance abuse, was urged to place her children with a friend of the family. When appropriate, the family workers counseled parents toward voluntary relinquishment rather than initiating court order action for termination of parental rights.

Re-referrals were handled somewhat inconsistently. When these families were recognized by the CPS Intake Supervisor as project families, and the project was still active or accepting cases, the information was forwarded to the appropriate family worker. When time permitted, the CPS liaison worker investigated re-referrals jointly with the family worker in order to corroborate the project's findings. Some of these re-referredfamilies, however, were erroneously assigned to CPS. Also, when the re-referral was of a serious nature and court action possible CPS would investigate the case.

The treatment process was characterized by several phases. The initial phase consisted of engaging the family in treatment. Obtaining the family's consent for services might take place within the first two to three weeks. A more active alliance might be achieved within six weeks, and in some instances this phase might take six months. Strategies for producing change in the initial phase of intervention were highly directive and goals were limited. During this phase, the most pressing family needs were met and problems requiring immediate attention were resolved. Basic necessities such as food, clothing and shelter were provided where lacking. Threats to the safety and well-bing of children and other family members were eliminated. Workers also began to develop sufficient influence with the families to facilitate these initial changes and to establish a basis for ongoing rapport. Isolated families were referred to other agencies and linked with extended families in order to expand the family's supportive network. Early changes tended to be superficial and might consist simply of eliminating the presenting problem. Frequently, families would reach a plateau, or leveling off period, during which no change was evident. This stage often resulted in worker frustration and anger which, unchecked, might lead to withdrawal and premature case closing.

Intensive supervision and consultation enabled workers to help a significant number of families make more permanent changes resulting in increased capacity for problem solving and enhanced parenting skills. The final phase of treatment involved instruction and demonstration around appropriate care giving to children, exploration of parental attitudes and personal problems, and involvement of parents in support groups.

Parents who were able to make long lasting changes were characterized by the capacity to form a relationship. Poor indicators for treatment were a sense of hopelessness on the part of the parents, lack of commitment to the child, below normal intelligence, poor physical or mental health, a previous history of multiple problems, lack of trust, and a sense of competence, and an externalized locus of control. Worker attitudes conducive to positive outcome were based on certain beliefs: 1) that most parents want to be better parents, 2) that given the appropriate skills and knowledge, most people who abuse or neglect their children can become adequate parents, and 3) that the achievement of limited goals can be a significant accomplishment.

Case Closing

The duration of services was originally to have been two years; however, some of the cases referred benefitted from brief treatment while others were chronic multi-problem situations requiring long-term treatment. The average length of services was one year; some families were seen for a shorter period and others much longer. The decision to close the case was made jointly by the worker and supervisor, with the Project Director's approval. Cases were closed when one or both of the following criteria were met: 1) that if a family were re-referred to CPS, no neglect or abuse would be found; 2) that the problems were resolved and the family was capable of seeking help elsewhere when needed. Some cases were closed becasue a family refused to sign Title XX authorization after 60 days; others were ready for closing, but were continued because a family did not want Title XX services such as day care discontinued. Cases were held open if a crisis such as birth of another child was anticipated. Some cases were closed because the family moved out of county. In these instances, referrals were then made to CPS in the new county of residence. Services were reactivated if the family moved back to Douglas County. Some cases were closed because the family worker left the project, particularly if there was no longer any risk to the child, if other agencies were involved and if transfer to a new worker would be difficult. During the final phase of the project, only one case was transferred to CPS because the child was at risk and the family wanted services. Transfer of cases to Douglas County Case Management Units was hindered by the project's lack of familiarity with DPW's referral procedures.

Record-Keeping

Both formal and informal case records were maintained. Case files bore the name of the head of household. The initial file received from CPS included copies of the CPS referral, intake investigation report, Title XX Social Services Application, and any prior CPS referrals and narratives.

As soon as the case was assigned, the worker began an informal log of actual and attempted contacts. These notes were kept with the worker. The worker also began to develop a problem list and a problem solving plan which were filed in the formal case file. These showed dates of contact, an objective statement of any problems, methods to be used to resolve them, and the results. After the initial staffing, the worker dictated a staffing report and the Assessment Specialist dictated test findings for inclusion in the record. Test protocols were also filed with the Specialist's reports. Each restaffing was dictated, and brief closing note summarizing the reasons for case closing was entered at termination. Case records also included any correspondence with other agencies. File contents were kept in loose folders with the following major divisions: CPS referrals, staffing reports, assessment information, collateral reports, correspondence, and problems and plans. The case records were maintained in a centrally located file cabinet and were locked at night.

During the final months of the project, cases were gradually transferred to CPS. The transferred record did not include the worker's weekly progress notes or test protocols. All other materials were transferred. Reports tended to be brief and objective, dictated in a telegraphic style that often minimized any findings of neglect or of use.

COMMUNITY CONTEXT--DOUGLAS COUNTY CHILD PROTECTIVE SERVICES

The Family Project was developed as an alternative to traditional child protective service delivery in Nebraska. The intent was to look at what supplemental services might be needed and how existing agency resources might be re-allocated to enhance the functioning of "at risk" families. The objective was to prevent the deterioration of levels of child care to such a degree that foster care placement might become necessary.

Although the focus of this process evaluation has been on the project itself, it is also important to examine the existing services of which it may impact. Child protective services have been provided in Nebraska since 1967 as part of the social services division of the State Department of Public Welfare. CPS services are funded by the state and administered by the counties who employ the workers. In 1977, a major policy decision was made by the State Department of Public Welfare to limit the provision of child protective services to a given family to a six-month period. Since that time, policy has been modified so that extensions may be granted for an additional six months of social services.

All reports of abuse and neglect in Douglas County are investigated by CPS. The intake investigation period, initially limited to 30 days, has recently been extended to 60 days. Seventy-five percent of the cases investigated are closed at intake for one of the following reasons: 1) report is unsubstantiated; 2) the situation can be resolved by referral out to other agencies that can provide concrete services and monitor the case; 3) the report is substantiated, but the family refuses social services; 4) a juvenile court petition is filed; or 5) the family cannot be located. During the intake investigation phase, the family may consent to six months of on-going services. At the end of this six months, the family may agree to na extension of services. The length of treatment in CPS cases is thus flexible and easily extended to 12 months.

In Douglas County there are a total of four units with seven workers each, and four supervisors. Workers have a MSW or an equivalent amount of education experience. There are usually several vacant positions due to a 50 percent annual turnover rate. One CPS unit is responsible for intake only, the other three accept referrals for on-going treatment. Caseload size ranges from 17 to 20. Cases in the on-going treatment units include voluntary services, home supervision of adjudicated dependency and neglect cases, and rehabilitation services for natural parents whose children are in foster care. Approximately half of the on-going cases are voluntary; the other half are involved with the juvenile court. When court action must be initiated, the on-going worker is responsible for investigating and providing information for the filing of a petition.

The frequency and type of services offered are comparable to those of the Family Project, but the worker's role differs. The CPS worker's role is primarily to provide support and to coordinate and manage the delivery of a range of services. The intent is to convert a relatively unwilling recepient of child protective services into a willing client of supportive services in the community. Due to caseload size, priority is given to cases in which a police report has been made and to families in which the target child is under six. When the family is not highly motivated to seek help, when there have been no prior referrals, and where the neglect or abuse is not substantiated, the family may receive minimal preventive services. Some cases are carried in which another agency worker is the primary service provider; in these instances, the CPS worker's role is one of coordinating and monitoring, only. The frequency of services in each case is reduced when the case is nearing termination. Cases are terminated when the referring problem and any other instance of neglect or abuse have been eliminated.

Case management decisions are typically discussed with the supervisor at intake, during assessment, ana at closing. Workers receive weekly individual supervision; supervision may be less frequent for experienced workers. Supervisors are also available as needed to assist with crises. Pediatric, psychological and legal consultation are readily available. consultation is most frequently used at intake to help determine the severity of neglect or abuse and to assist in making appropriate referrals. The consulting psychologist is available to provide diagnostic evaluations of children and parents when these cannot be obtained privately and when workers need recommendations of a practical, concrete nature. Workers have received training from consultants on cush topics as child development, identification of emotional disturbance, the use of psychological testing and reality therapy. The in-service component at CPS has imparoved with the departmental transfer of a social services training specialist to the CPS supervisory staff.

In general, workers find that the range of services available in the community are adequate to meet family needs. Community mental health services are frequently utilized as the primary providers of direct treatment. A number of parent groups are available in the community. There are no specialized groups for multi-problem families, however, and at times mental health professionals are insufficiently trained to work with neglectful and abusive parents.

A worker may refer a child for voluntary foster care when a parent is overwhelmed by stress and lacks the material or emotional resources to provide for the child's well-being. Typical reasons for using voluntary foster care are hospitalization of a parent for childbirth or physical or mental illness; incarceration; and lack of finances to provide a residence or food for a child. The limit on using voluntary foster care in Douglas County is two to three weeks. After that time, if other resources cannot be mobilized, court action will be initiated to declare a child a dependent. Foster care placement can also be court ordered in cases in which: 1) a child is in immediate danger by reason of neglect or abuse; or 2) work with a family has been ineffective and remaining in the home is detrimental to a child's well-being. The actual decision to place a child in the first instance rests with the police, who can remove a child from the home, and in the latter, with the county attorney, who can approve the filing of a dependency or neglect petition.

Motivating factors in a worker's request for court action may be anxiety and concern for the child's well-being, pressure from a physician who believes removal is necessary to protect the child, or frustration when a family is unresponsive to CPS intervention. In particular, a family may not recognize the problem (e.g., due to the ignorance), deny a problem exists, or respond to services offered with an attitude of apathy and hopelessness. Experienced protective services workers often tend to receive cases as fitting a pattern and may believe that a family situation is unlikely to improve based on the similarity of that situation to previous cases. This phenomenon is often a sumptom of "burnout," and frequently appears after two or more years of experience in protective services.

The decision to file a petition must be approved by the county attorney, who looks at four factors. First, there must be sufficient evidence to sustain a petition, such as expert testimony, police reports, and witnesses who will testify. Secondly, the problems must be multiple, chronic, and/or severe. In essence, a parent must be failing to meet a child's basic needs and lack affection for the child and these conditions must have a detrimental effect on the child. Thirdly, services must have been made available to the family over a reasonable period of time (three to six months). And finally, the parents must evidence lack of motivation in that they have failed to actively participate in a service plan.

When children are placed outside the home, the protective services worker remains the worker for the natural parent while the child's case is transferred to a foster care worker who works with the child and foster parents. At this point, the worker becomes a member of a multi-disciplinary team--consisting of a CPS worker, foster care worker, court service worker, and a guardian at litem--who collaborate on services to the family and eventually decide when a child is to be returned to the home or whether parental rights are to be terminated. Dependencey cases are reviewed every three to six months. There is no statutory time frame in Nebraska for termination of parental rights.

Protective services' workers are faced daily with difficult and emotionally draining decisions. They work with cases ranging in severity from moderate to extreme. Administrative supports necessary to prevention of "burnout" are lacking. While supervisors and co-workers are available for listening to frustrations, offering support, and appreciating successes, CPS units are isolated from other service units in DPW and workers have little access to administration. The work environment, itself, is drab and overcrowded, with inadequate privacy and space for interviewing clients or dictating reports. Salaries are low. A decreasing number of MSWs and men are attracted to the position. Personnel policy does not permit flex time hours for part-time employment.

SUMMARY AND CONCLUSION

Successful Results

The chief differences between services provided to the Family Project and those Douglas County CPS seem to lie not in the area of frequency and type of services, but in the conditions under which case work decisions are made. Project workers were under somewhat less time pressure and had more available support and direction in everyday decision making. While they carried almost as many cases as CPS workers and felt restricted by the six-month service renewal process, the family workers were not pressured by working with families whose children were in immediate danger or with obtaining information for filing petitions or with responsibility for rehabilitating court involved families.

The importance of support in casework decision-making cannot be underestimated when one is working with essentially involuntary and typically ungrateful clients who do not change rapidly. The worker's sense of responsibility where there is high risk can be burdensome. The cosio-economic restrictions of low-income families become depressing to the empathic worker who strives to be a change agent. Also, the feeling one is invading a family's privacy by penetrating its barriers is distasteful to many workers.

Family workers received both support and direction in their casework decision-making. Their supervision, consultation and training were, in general, more frequent and intense than that of CPS workers. Just with work with multi-problem families requires a more structured, directive approach and persistent follow-through, supervision in the Family Project was characterized by structure, directiveness and systematic review. Reviews allowed workers to assess the effect of their intervention and to modify their goals and strategies where needed. Periodic review permitted workers to ventilate feelings of frustration about slow or unchanging families to adjust expectations where appropriate and to persist with needed intervention rather than to withdraw prematurely.

The interdisciplinary team approach encouraged comprehensive assessment and shared decision-making as well as creative problem solving and developing strategies for change. Decisions were made on the basis of thorough assessment, including worker observation, information elicited from the family, and formal disgnostic testing. Responsibility for decision-making was shared with experts from other disciplines. Decision-making skills were enhanced by the on-going staff development inherent in the process of discussing alternative approaches to problem solving.

The reduced pressure and extensive support system provided helped to alleviate worker stress and anxiety and enable workers to make objective therapeutic decisions. These conditions facilitated the development of positive relationships with the clients served and enabled the worker to focus on family strengths and to avoid being overwhelmed by family dysfunction. Client-worker relationships were characterized by empathy and positive regard rather than the guarded cynicism and pessimism typical of "burnout." Workers tended to be strong advocates for their clients and were not easily daunted by the complexities and frustrations of the welfare system. Clients responded to the quality of involvement with trust, and at times gratitude. They viewed family workers as less coercive than CPS workers and felt they were treated as individuals of worth. One depressed mother, embittered by the initial to CPS, stated emphatically the family worker had treated her "like a person." The quality of the woer-client relationship was paralleled by the improved quality of parent-child interaction in many cases and the increased sensitivity of the parent to the child's needs.

Whereas the Family Project provided direct services of an educational, therapeutic type, particularly in the latter stages of treatment, CPS tends to confine itself to service linkage and coordination and to delegate intensive treatment to mental health professionals in the community. The latter approach may be cost ineffective, particularly with chronic cases, in that the time of mental health professionals is more costly than that of social service providers. The Family Project demonstrated that highly trained social workers can be quite effective in reaching multi-problem families. The use of diagnostic testing and evaluation by mental health specialists was, however, important for the early detection of handicaps and the development of early intervention strategies such as infant stimulation and specialized school placement.

The Family Project and CPS followed similar criteria for the use of foster care. The Family Project tended not to use county funded foster care because of the difficulty of access for a non-welfare based program. Also, the Family Project tended to counsel natural parents toward voluntary relinquishment when permanent planning for out-of-home care became necessary.

Areas for Improvement

The multi-disciplinary problem solving approach requires a mutual sense of trust and respect among members of different disciplines. The cooperation that existed between a psychologist and social workers , the predominant professionals in the project, was endangered from the outset by tensions between research and treatment needs. These needs became increasingly polarized and, as a result, maximum use was not made of diagnostic testing and psychiatric consultation. Diagnostic testing of individual children revealed important developmental gains in those families where the research model was followed. In some instances, postponement of testing resulted in delayed detection of handicaps and less directive intervention from the outset.

Formal dissemination of information about the project was largely a function of its concluding phase. The project did participate in city-wide and statewide groups for the development and coordination of services to abusive and neglectful families. Face-to-face collaboration with generic agencies, particularly during the initial and re-staffings, also served to provide information and insight into the project's methodology. CPS made changes during the project's existence that served to bring it somewhat closer in operation to the project. Nevertheless, it is unclear what interest the NDPW has in replicating important aspects of the program elsewhere and dissemination tasks will probably need to be continued after project operations have ended.

Implications for Cost-Effective Replication

At minimal additional cost, the use of group supervision and multi-disciplinary staffed case conferences could be implemented at Doughlas County CPS. Group supervision and multi-disciplinary staffings in the project both served to enhance worker skills in problem solving and to create a supportive sense of shared decision making. CPS could staff intakes and periodic reviews with its multi-disciplinary consultants. Additionally, the use of consultants could be extended to making joint home visits for the purpose of assessment,to the projected testing of parents and to increased availability to workers for informal consultation.

A half-time psychologist and a four-hour per week psychiatrist would be important additions to CPS staff. The cost of hiring such specialists could be off-set by using highly trained case aids to service the more chronic cases in need of long-term shpport. At the minimum, CPS workers should be trained when and how to refer clients for psychological testing and psychiatric evaluation, and these resources should be readily available.

As stated earlier, the referral out of cases for mental health treatment of parenting difficulties and dysfunction may be more costly in the long run than provision of intensive casework by highly trained social workers. Additionally, many CPS families have such multi-faceted problems that highly specialist services are needed to engage and maintain them in treatment. The Family Project clearly provided such a blend of casework and educational and therapeutic approaches to benefit a high risk population of children and families.

APPENDIX B

EXIT INTERVIEW

PART I: BACKGROUND

Interviewer: In this first part, we will get some basic questions out of the way. I'll be asking questions like who lives with you, what education you've had, what your financial situation is, etc.

1. How many children do you have?

1 2

2. How many of these are living at home?

3 4

3. What are the sex and ages of your children beginning with the oldest? (Probe where living and when and why left home.)

5 6 7	a.	____ sex	____ age	______________ name	______________ when and why left
8 9 10	b.	____	____	______________	______________
11 12 13	c.	____	____	______________	______________
14 15 16	d.	____	____	______________	______________
17 18 19	e.	____	____	______________	______________

20

4. Are you single, married, coupled, widowed, separated, divorced, other?

(Circle one.)

a. (If in a relationship), How long have you been? ______________

21 22

5. Aside from you and (others mentioned) is anyone else living here now? (Probe for friend or relative.)

23

a. ____________ : ____________
name relation

b. ____________ : ____________
name relation

c. ____________ : ____________
name relation

6. How old are you?

24 25

a. How old is (partner)?

26 27

7. What do you do with your time? Are you working? Part-time? Full-time? (Score: 0, 1, 2) ______________

28

8. What does (partner) do? Part-time? Full-time? (Score: 0, 1, 2)
____

29

9. What were you doing with your time when you began receiving services from your CPS social worker? Were you working? Part-time or full-time? (Score: 0, 1, 2)
____

30

Part I: Background, continued

10. What was (partner) doing with his time?

31 ______________________________

32 33 11. What is the highest grade you completed in school?

34 35 12. Did you work before you had children? Full-time? How much? (Indicate whether mostly full-time or part-time. If worked intermittently, count that as part-time.) (Score: 0, 1, 2.)

____

36 37 38 39 13. About how much income does the family have per month?

______________ (total)

40 41 42 43 a. From employment ______________

44 45 46 47 b. From public assistance ______________

48 49 50 51 c. From other sources ______________

Interviewer: Now I'd like to know if anything happened to you or a family member in the year before you began receiving services from your social (family) worker that might have been upsetting to you or that might have changed things.

14. During the year before you began receiving services from your social worker. . . . (Check any that apply.)

52 a. Did you become pregnant or have a new baby?

53 b. Did you become separated or divorced? Break up with a girl/boyfriend?

54 c. Were you hospitalized for a physical illness or did you suffer from a chronic illness?

55 d. Hospitalized for a mental illness or did you suffer from a psychological or emotional problem?

56 e. Did you move? How many times? (Record number.)

57 f. Did a close friend or relative die? Or move out of the area?

58 g. Did you lose a job or your source of financial support?

59 h. Were you arrested (excluding traffic violations)?

60 i. Did a new person join your household (excluding a new baby)?

61 j. Was someone else in your household hospitalized for a physical illness or did he/she suffer from a chronic illness?

62 k. Was someone else in your household hospitalized for a mental illness, or did he/she suffer from a psychological or emotional problem?

l. Did you or partner start a new job or start school? ___ 62

m.. Did you begin a couple relationship? ___ 64

n. Did a machine you relied on breakdown? ___ 65

Part I: Background, continued

15. During the time you (were) (have been) receiving services from your (social) (family) worker. (Check any that apply. Do not check if stress originated in year prior to services and was checked above.)

a. Did you become pregnant or have a new baby? ___ 64

b. Did you become separated or divorced? Break up with a girl/boyfriend? ___ 65

c. Were you hospitalized for a physical illness or did you suffer with a chronic illness? ___ 66

d. Were you hospitalized for a mental illness or did you suffer from a psychological or emotional problem? ___ 67

e. Did you move? How many times? (Record number.) ___ 68

f. Did a close friend or relative die? Or move out of the area? ___ 69

g. Did you lose a job or your source of financial support? ___ 70

h. Were you arrested (excluding traffic violations)? ___ 71

i. Did a new person join your household (excluding a new baby)? ___ 72

j. Was someone else in your household hospitalized for a physical illness or suffered from a chronic illness? ___ 73

k. Was someone else in your household hospitalized for a mental illness, or did he/she suffer from a psychological or emotional problem? ___ 74

l. Did you or partner start a new job or start school? ___ 75

m. Did you begin a couple relationship? ___ 76

n. Did a machine you relied upon breakdown? ___ 77

PART II: SERVICE SUMMARY-SPECIFIC

Now I am interested in learning about the experience you have had with (CPS)(The Family Project) since you began receiving services from them. First I'd like to find out which things your worker discussed with you then what your worker did to help with the problems s/he discussed with you.

1. Here are some problems that (social)(family) workers often discuss with families. Some ways that (social)(family) workers indicate they believe something is a problem is to say "I'm concerned about that" or "I think there may be a problem around this" or "I really want you to do something about that (e.g. get some time for yourself)".

   Did your (social)(family) worker see any of these as problems for you or your family? I will read over a list of problems and I'd like you to give me a simple yes or no answer if your (social)(family) worker ever discuss this problem with you. (Probe: Did s/he discuss it with you more than once?)

   Instruction: If worker discussed this problem with the client more than once, check the problem in Column A of the Score Sheet. Read problems 1-49.

2. Here are some of the problems that often come up in families concerning the children. Did your (social)(family) worker see any of these as problems for your child/children? I will read over a list of children's problems and I'd like you to give me a simple yes or no answer again if your (social)(family) worker ever discussed this problem with you. (Probe: Did s/he discuss this with you more than once?)

   Instruction: If worker discussed the problem with the client more than once, check the problem in Column A of the Score Sheet. Read child problems.

3. Are there any other problems your (social)(family) worker discussed with you that we have not covered? What are they? (Probe: Did s/he discuss this with you more than once?)

   Instruction: Record these as Other Problems on p. 6 of Score Sheet if problem does not fit a given category previously mentionned. Specify whose problem it is and the nature of the problem. Check Column A. Refer to these problems in further questions regarding problems identified in Column A.

4. Which of these problems did your (social)(family) worker consider the most important, i.e. which did s/he discuss with you most?

   Instruction: Select a maximum of 5 problems. Circle up to 5 problems checked in Column A: (✓)

5. When your (social)(family) worker first began discussing these things with you, did you feel they were problems or needed changing? I'll go over the problems your (social)(family) worker discussed with you. Please give a simple yes answer if you agreed that it was a problem at first, or no if you did not agree at first.

   Instruction: Check yes responses only in Column B, next to problems checked in Column A.

PART II: SERVICE SUMMARY-SPECIFIC Continued.

6. Now I'd like to know what kinds of things the (social)(family) worker did to help you with the things s/he thought were problems. Please answer yes or no if the (social)(family) worker did any of the following things. (Check any yes responses.)

   a. Helped you to express or recognize your true feelings. ___ 1

   b. Gave you advice or suggestions; gave information. ___ 2

   c. Taught you or helped you to understand what is normal behavior or normal feelings, how to make sense of your life experiences. ___ 3

   d. Arranged with somebody else for you to get something. ___ 4

   e. Helped you to feel better about yourself or to recognize your own strengths. ___ 5

   f. Supported you in your efforts or cheered you on in your efforts. ___ 6

   g. Showed you how to do something; taught you a new way to manage a problem. ___ 7

   h. Taught you how to get things or how to get things done for yourself. ___ 8

   i. Shared the work on a problem with you. ___ 9

   j. Set limits on what you should or should not do. ___ 10

   k. Took you somewhere or went somewhere with you. ___ 11

   l. Taught you how to handle your child's/children's misbehavior. ___ 12

   m. Listened to you when you were upset without putting you down. Understood you. ___ 13

   n. Other things. Specify: ___ 14

   o. Other things. Specify: ___ 15

7. Now I'd like to know what changes you believe have occurred in each of the problems your (social) (family) worker discussed with you. (Probe: Can you give me an example of what is different now?)

   Scoring:
   1--Much worse.
   2--Slightly worse.
   3--No change or no specific progress.
   4--Slightly better.
   5--Much better, or problem resolved.
   9--Cannot or will not say.

   Instruction: Select appropriate score for each problem checked in Column A. Circle score in Column C. Determine score on basis of facts given.

8. Usually (social)(family) workers and clients agree on the amount of change that has taken place and I assume your (social)(family) worker and you do agree on most of these. But I'd like to know if you think your (social)(family) worker would disagree significantly with you on the amount of change that has occurred with any of the problems we have discussed. Which problems are they?

Instruction: Check those problems for which client indicates a belief there would be significant disagreement between his/her assessment and the worker's. Place checks in Column D.

9. Do you believe there have been any other changes in you or your family since you began seeing the (social)(family) worker? (Probe: Can you give me an example of what is different now?)

Scoring:

1--Much worse.

2--Slightly worse.

3--No change.

4--Slightly better.

5--Much better.

Instruction: Do not read list. You only need to select scores for problems mentionned by client. You will not need to use the score of 3 since all unmarked problems will receive an automatic 3. Circle score in Column E. Choose score on basis of facts given.

PART III: SERVICES PROVIDED

Interviewer: Now I'd like to ask you about which services you were offered and which you participated in or received.

1. Did the first person you saw from Child Protective Services, not your regular (social) (family) worker, refer you to any place or take care of an emergency need that couldn't wait? (Explain what a service is.)

   (Check any services mentioned under the Intake column on the Service List.)

2. Now I'd like to know what services your (social) (family) worker got you. Did s/he get you... (Probe: How long/how many times did you participate?)

   a. Help for taking care of your child(ren), e.g., day care, a parenting group, foster care, etc.?

   b. Help for housekeeping or housing problems, e.g., chore services, homemaker, new housing, needed equipment, etc.?

   c. Help with family or personal problems, e.g., counseling, therapy, family planning, etc.?

   d. Medical help, e.g., medical care, medicaid, nutrition or health services, etc.?

   e. Financial or job help, e.g., assistance, food stamps, job training, education, employment services, etc.?

   f. Other services, e.g., court services, transportation, day care for adults, legal services, recreation, emergency services, a self-help group, etc.?

   Instruction: Check any services worker provided and client participated in in the Worker Provided column of the Service List, p. 7. Do not count if client attended an ongoing service, e.g. a class or parenting group, only once or twice then dropped it.

3. Were you offered any of these services by anyone other than your (social) (family) worker? Did you participate in any of these?

   Instruction: Check if client participated. Check Other Service column.

4. Did you arrange or find any services on your own? (Probe: Did you worker help you find or arrange these services?)

   Instruction: If worker took an active role, e.g. gave a name or phone number to the client who then arranged the service, credit the worker by checking this in the Worker Provided column--do not credit client unless s/he sought the service unassisted. If credit goes to client, check Client Sought column.

PART III: SERVICES PROVIDED , Continued.

5. Instruction: Ask only if client participated in a service provided by someone other than the worker or sought it on his/her own, i.e. if services were checked under Other Service or Client Sought columns.

Why did you get or accept these services from someone other than your (social)(family) worker? (Probe: Did your worker know you might have needed or wanted this service?)

Scoring:
1--Coerced by outside individual or agency.
2--Worker did not know of need or interest on part of client.
3--Worker knew of need or interest but did not or could not offer this service.
4--Worker encouraged client to seek service on his/her own.
5--Another agency or individual offered this service.

Instruction: Fill in score for each applicable service in final solumn of Service List under CAUSE.

Interviewer: Now I'd like to get your opinion of the services you received.

6. Why did you accept services from (CPS) (The Family Project)? (Probe: Did you think they might take your child from you? Did you want the help?)

Scoring:
1--Felt threatened, coerced; feared loss of child.
2--Felt threatened, coerced, but also wanted help.
3--Welcomed help.

Instruction: Probe for any reasons. Determine main reason. Circle response on bottom of Service List.

7. I'd like you to give me your overall opinion of how helpful your experience with the (social)(family) worker was in dealing with the problems you discussed with him/her. Please say whether you believe the worker was of little or no help, somewhat helpful, or very helpful.

Scoring:
1--Little or no help.
2--Somewhat helpful.
3--Very helpful.

Circle response on bottom of Service List.

PART III: SERVICES PROVIDED, Continued.

8. Terminated Cases Only: Do you feel things are harder now for you or your family since you stopped receiving services from (Children's Protective Services)(The Family Project)? How much harder?

Scoring: 1--No harder.
2--Somewhat harder.
3--Much harder.

Circle response on bottom of Service List.

9. Ask if client felt things are harder now: What is harder now?

Instruction: Check any reasons given and specify those reasons on bottom of Service List. Continue on back side if necessary.

PAGE 1

PROBLEM LIST AND SCORE SHEET

ISFAR FAMILY INTERVIEW: FIRST EVALUATION

PROBLEMS	A	B	C	D	E
HOUSING PROBLEMS					
1. Crowded conditions	___	___	1 2 3 4 5 9	___	1 2 3 4 5
2. Neighborhood safety	___	___	1 2 3 4 5 9	___	1 2 3 4 5
3. Needed repairs, fire or safety hazard, ventilation, or problems with pests	___	___	1 2 3 4 5 9	___	1 2 3 4 5
PHYSICAL HEALTH PROBLEMS OF ADULTS					
4. Mother	___	___	1 2 3 4 5 9	___	1 2 3 4 5
5. Father/Partner	___	___	1 2 3 4 5 9	___	1 2 3 4 5
6. Other--specify: ______________________ ______________________	___	___	1 2 3 4 5 9	___	1 2 3 4 5
FINANCIAL PROBLEMS--Problems with Unemployment--Can't Find a Job					
7. Mother	___	___	1 2 3 4 5 9	___	1 2 3 4 5
8. Father/Partner	___	___	1 2 3 4 5 9	___	1 2 3 4 5
9. Other--specify: ______________________ ______________________	___	___	1 2 3 4 5 9	___	1 2 3 4 5
10. Lacking necessities	___	___	1 2 3 4 5 9	___	1 2 3 4 5
11. A lot of bills you can't pay, managing	___	___	1 2 3 4 5 9	___	1 2 3 4 5
PROBLEMS AT WORK					
12. Mother	___	___	1 2 3 4 5 9	___	1 2 3 4 5
13. Father	___	___	1 2 3 4 5 9	___	1 2 3 4 5
14. Other--specify: ______________________ ______________________	___	___	1 2 3 4 5 9	___	1 2 3 4 5

PROBLEM LIST AND SCORE SHEET

ISFAR FAMILY INTERVIEW: FIRST EVALUATION

PROBLEMS	A	B	C	D	E
HOUSEKEEPING: KEEPING THE HOUSE CLEAN OR SAFE FOR CHILDREN					
15. Clean house	___	___	1 2 3 4 5 9	___	1 2 3 4 5
16. Safe for child/children	___	___	1 2 3 4 5 9	___	1 2 3 4 5
HOUSEHOLD ROUTINE: REGULAR MEALS AND BEDTIMES FOR CHILD(REN)					
17. Mother (Primary Caretaker)	___	___	1 2 3 4 5 9	___	1 2 3 4 5
PSYCHOLOGICAL PROBLEMS OF ADULTS					
18. Mother	___	___	1 2 3 4 5 9	___	1 2 3 4 5
19. Father/Partner	___	___	1 2 3 4 5 9	___	1 2 3 4 5
20. Other--specify: ____________ ____________	___	___	1 2 3 4 5 9	___	1 2 3 4 5
FAMILY MEMBERS NOT GETTING ALONG--ADULTS OR CHILDREN OVER 7 YEARS					
21. Marital discord	___	___	1 2 3 4 5 9	___	1 2 3 4 5
22. Family discord (over 7 yrs.)					
MANAGING A DIFFICULT CHILD/MEANS OF DISCIPLINE USED					
Strict Discipline/Too Restrictive					
23. Mother	___	___	1 2 3 4 5 9	___	1 2 3 4 5
24. Father/Partner	___	___	1 2 3 4 5 9	___	1 2 3 4 5
25. Other--specify: ____________ ____________	___	___	1 2 3 4 5 9	___	1 2 3 4 5
Physical Punishment					
26. Mother	___	___	1 2 3 4 5 9	___	1 2 3 4 5
27. Father/Partner	___	___	1 2 3 4 5 9	___	1 2 3 4 5
28. Other--Specify: ____________ ____________	___	___	1 2 3 4 5 9	___	1 2 3 4 5
Specify Abuse: ____________ ____________	___	___	1 2 3 4 5 9	___	1 2 3 4 5

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PROBLEM LIST AND SCORE SHEET

ISFAR FAMILY INTERVIEW: FIRST EVALUATION

PROBLEMS	A	B	C	D	E
Consistency/Firmness					
29. Mother	___	___	1 2 3 4 5 9	___	1 2 3 4 5
30. Father/Partner	___	___	1 2 3 4 5 9	___	1 2 3 4 5
31. Other--specify: ________________ ________________	___	___	1 2 3 4 5 9	___	1 2 3 4 5
Easily Upset by Child's Misbehavior					
32. Mother	___	___	1 2 3 4 5 9	___	1 2 3 4 5
33. Father/Partner	___	___	1 2 3 4 5 9	___	1 2 3 4 5
34. Other--specify: ________________ ________________	___	___	1 2 3 4 5 9	___	1 2 3 4 5
USE OF DRUGS OR ALCOHOL					
35. Mother	___	___	1 2 3 4 5 9	___	1 2 3 4 5
36. Father/Partner	___	___	1 2 3 4 5 9	___	1 2 3 4 5
37. Other--specify: ________________ ________________	___	___	1 2 3 4 5 9	___	1 2 3 4 5
LEGAL PROBLEMS (Non-Traffic)					
38. Mother	___	___	1 2 3 4 5 9	___	1 2 3 4 5
39. Father/Partner	___	___	1 2 3 4 5 9	___	1 2 3 4 5
40. Other--specify: ________________ ________________	___	___	1 2 3 4 5 9	___	1 2 3 4 5
RELIEF FROM CHILDCARE/TIME FOR YOURSELF					
41. Mother (Primary Caretaker)	___	___	1 2 3 4 5 9	___	1 2 3 4 5
FRIENDSHIP/SOMEONE TO COUNT ON OR TO TALK WITH					
42. Mother (Primary Caretaker)	___	___	1 2 3 4 5 9	___	1 2 3 4 5

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PROBLEM LIST AND SCORE SHEET

ISFAR FAMILY INTERVIEW: FIRST EVALUATION

PROBLEMS	A	B	C	D	E
MORE CHILDREN THAN YOU REALLY WANTED					
43. Mother (Primary Caretaker)	___	___	1 2 3 4 5 9	___	1 2 3 4 5
SUPERVISING YOUR CHILD(REN)-- someone there when you are not, responsible sitters, leaving a young child to care for other children, leaving a child alone?					
44. Leaving alone or Abandonment. Specify: ___	___	___	1 2 3 4 5 9	___	1 2 3 4 5
45. Inadequate supervision by parent	___	___	1 2 3 4 5 9	___	1 2 3 4 5
46. Inadequate child care/sitters	___	___	1 2 3 4 5 9	___	1 2 3 4 5
HIGH EXPECTATIONS					
47. Expecting too much of yourself; being too hard on yourself.	___	___	1 2 3 4 5 9	___	1 2 3 4 5
48. Asking a child to do things he is not really old enough to do or that parents should do instead. Having your child take care of you	___	___	1 2 3 4 5 9	___	1 2 3 4 5
MEDICAL CARE					
49. Getting needed medical care of medicine for child(ren).	___	___	1 2 3 4 5 9	___	1 2 3 4 5

PROBLEM LIST AND SCORE SHEET

ISFAR FAMILY INTERVIEW: FIRST EVALUATION

PROBLEMS	A	B	C	D	E
PROBLEMS OF CHILD--"A Child who..."					
50. Gets upset if s/he makes a mistake, gets dirty, or loses things. Child: ________	___	___	1 2 3 4 5 9	___	1 2 3 4 5
51. Is always getting sick. Child: ________	___	___	1 2 3 4 5 9	___ ___	1 2 3 4 5
52. Is physically handicapped. Child: ________	___	___	1 2 3 4 5 9	___	1 2 3 4 5
53. Is a slow learner or has a developmental delay. Child: ________	___	___	1 2 3 4 5 9	___	1 2 3 4 5
54. Is mentally retarded. Child: ________	___	___	1 2 3 4 5 9	___	1 2 3 4 5
55. Is overly sensitive. Child: ________	___	___	1 2 3 4 5 9	___	1 2 3 4 5
56. Has nightmares, or refuses to eat, or is over 5 and wets the bed. Child: ________	___	___	1 2 3 4 5 9	___	1 2 3 4 5
57. Has worries or fears that won't go away; is overly cautious. Child: ________	___	___	1 2 3 4 5 9	___	1 2 3 4 5
58. Often plays hooky from school. Child: ________	___	___	1 2 3 4 5 9	___	1 2 3 4 5
59. Is not working up to ability in school. Child: ________	___	___	1 2 3 4 5 9	___	1 2 3 4 5
60. Has frequent temper tantrums. Child: ________	___	___	1 2 3 4 5 9	___	1 2 3 4 5

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PROBLEM LIST AND SCORE SHEET

ISFAR FAMILY INTERVIEW: FIRST EVALUATION

PROBLEMS	A	B	C	D	E
61. Is overly aggressive. Child: ______	___	___	1 2 3 4 5 9	___	1 2 3 4 5
62. Is generally withdrawn or unhappy; a loner. Child: ______	___	___	1 2 3 4 5 9	___	1 2 3 4 5
63. Pretends to be sick. Child: ______	___	___	1 2 3 4 5 9	___	1 2 3 4 5
64. Is nervous or becomes anxious and goes to pieces. Child: ______	___	___	1 2 3 4 5 9	___	1 2 3 4 5
65. Lies or steals. Child: ______	___	___	1 2 3 4 5 9	___	1 2 3 4 5
66. Has frequent accidents. Child: ______	___	___	1 2 3 4 5 9	___	1 2 3 4 5
67. Weighs too little or too much. Child: ______	___	___	1 2 3 4 5 9	___	1 2 3 4 5
68. Physical appearance or clothing. Child: ______	___	___	1 2 3 4 5 9	___	1 2 3 4 5
OTHER PROBLEMS (ADULTS, CHILDREN)					
69. Who? ______	___	___	1 2 3 4 5 9	___	1 2 3 4 5
Problem: ______	___	___	1 2 3 4 5 9	___	1 2 3 4 5
70. Who? ______	___	___	1 2 3 4 5 9	___	1 2 3 4 5
Problem: ______	___	___	1 2 3 4 5 9	___	1 2 3 4 5

SERVICE LIST	INTAKE	WORKER OFFERED	WORKER PROVIDED	OTHER SERVICE	CLIENT SOUGHT	CAUSE
1. Day Care Services for Children						
2. Parenting Group						
3. Foster Care Services						
4. Chore Services						
5. Homemaker Services						
6. Housing Services						
7. Emergency Needs Services						
8. Counseling and Treatment-Referral						
9. Family Planning Services						
10. Family and Personal Adjustment Counseling						
11. Health-Related Services						
12. Nutrition-Related Services						
13. Medicaid						
14. Food Stamps						
15. Education and Training						
16. Employment Services						
17. Court Services						
18. Transportation Services						
19. Socialization/Recreation Services						
20. Day Care Services for Adults						
21. Legal Services						
22. Self-Help Group						
23. Hotline, Community Outreach						
24. Non-Title XX Emergency (specify):						
1. ________						
2. ________						
25. "Innovative" (specify):						
1. ________						
2. ________						
26. Other (specify):						
1. ________						
2. ________						

6. Reason: 1 2 3

7. Help: 1 2 3

8. Harder: 1 2 3

9. Why harder:

___ a. Loss of referred services.

___ b. Loss of (social)(family) worker.

___ c. Change in family circumstances not related to service termination.

Specify:

POST-INTERVIEW CHECKLIST

Check the degree to which you found each of the following:

1. Cleanliness of the home:

___ 1. Acceptable
___ 2. Dirty
___ 3. Extreme filth. Garbage, refuse, or feces strewn about, etc.

Comments:

2. Mother's ability to comprehend questions:

___ 1. Good
___ 2. Fair
___ 3. Poor. Needs much interpretation

Comments:

3. Mother takes initiative in completing questionnaire:

___ 1. Takes initiative
___ 2. Wants some help
___ 3. Asks for or requires much help in reading or answering questions

Comments:

4. Mother's cooperativeness with the interview:

___ 1. Cooperative
___ 2. Somewhat resistant; some trouble remembering or focusing attention
___ 3. Extreme reluctance to participate; great difficulty remembering or focusing attention. (Mother may use household distractions to avoid interview.)

Comments:

5. Physical state of child(ren) observed:

Name: ____________________	Name: ________________	Name: ___________________
____ 1. Good	____ 1. Good	____ 1. Good
____ 2. Fair	____ 2. Fair	____ 2. Fair
____ 3. Poor	____ 3. Poor	____ 3. Poor

Comments:

6. Mother's social interaction with child(ren):

Comments:

7. Mother appears: (Check any that apply)

____ 1. Depressed, withdrawn, energyless
____ 2. Agitated, nervous, or signs of emotional disturbance
____ 3. Drugged or drunk
____ 4. Other--specify: ________________________________

Comments:

8. Physical condition of the home. (Check any that apply.)

___ 1. Crowding
___ 2. Needed repairs, safety hazards
___ 3. Lack of furniture, beds
___ 4. Poor lighting, ventilation or heating

Comments:

Appendix B

ISFAR Entry Criteria

INITIAL CRITERIA FOR INCLUSION IN STUDY:

1. Conditions of children:

   a) physical neglect: child is undernourished; is underdressed for cold weather or overdressed for hot weather, has repeated accidents; is filthy; is allowed to enter or is placed in unsafe environments.

   b) medical neglect: child does not receive treatment for acute or chronic illness(es).

   c) emotional neglect: parents are unresponsive to child's communications; child is placed with a variety of babysitters on an irregular schedule.

   d) educational deprivation: child is frequently kept at home by parents for housekeeping or babysitting services; child is permitted to reamin at home because of unwillingness to attend school.

   e) physical maltreatment: child shows repeated bruises or injuries that are thought to be caretaker inflicted; confinement for long periods and/or by harsh means.

   f) emotional maltreatment: continued and harsh rejection and scapegoating of child by caretakers.

   g) lack of supervision: child is under 12 and is repeatedly left without an adult or a babysitter in attendance.

2. Conditions of parents:

   a) parent misuses drugs or alcohol.

   b) parent has a disease or disability that impairs capacity to parent.

   c) parent displays an emotional problem that impairs parental functioning or places them at high risk for impaired parenting (e.g. drug addiction, history of violence).

   d) parent shows signs of lack of control or fear of losing control.

   e) parent is uncommitted to child or unresponsive to child's needs.

   f) parent expresses unrealistic expectations of child and attempts to enforce these.

g) parent displays poor parenting skills.

h) parent is cruel or sadistic.

3. Family conditions:

a) family is experiencing a crisis, due to loss of job, illness, lack of cooperation among members, change in family consultation, financial problems.

4. Physical environment:

a) housing does not meet health standards.

b) housing is unsafe.

5. At least one parent, relative, or guardian who has cared for the children since birth or the past three years is available for services to assist them to continue to care for the child(ren).
6. The family is eligible for services from Douglas County C.P.S.
7. Must be a child in the family who is seven or younger.

II. CRITERIA FOR EXCLUSION FROM STUDY:

1. A child is regarded as in "imminent peril" when it's physical safety, health needs or emotional well being are gravely jeopardized by remaining in the home. Children in imminent peril are not included.
2. Families having children aged seven or younger that do not display problems caring for their children are ineligible.
3. Familes that have had children placed in foster care for reasons of dependancy, neglect or abuse during the past three years are not eligible for this project.
4. Families that have previously received C.P.S. services are not eligible except in cases in which a problem existed and has been resolved and a new problem has arisen or the same problem has reoccured but with a different child.

8-8-78

FINAL CRITERIA FOR ENTRY IN PROJECT

1. Family has a child under 7 years of age.
2. Court referral is not planned at time of entry into CPS.
3. Family is eligible for CPS services.
4. All criteria for inclusion previously described.

Appendix C

Family Interview

FAMILY INVENTORY

A--BOUNDARY PERMEABILITY

1. Did you or someone from your home or family call C.P.S. about (child's name)?

2. Have you been in contact with any service agencies or organizations during this past year?

   If so, how many?

3. Have you moved during the last year?

   If so, how many times?

4. Have any friends or relatives lived with you, or have you lived with them for a month or longer during the past year?

5. How much of your job as a parent is being taken over by other people?

	VERY MUCH	PRETTY MUCH	SOME	A LITTLE	NONE AT ALL
MOTHER:	1	2	3	4	5
FATHER:	1	2	3	4	5

6. How much do case workers and doctors listen to your ideas about what is best for your family?

	VERY MUCH	PRETTY MUCH	SOME	A LITTLE	NONE AT ALL
MOTHER:	1	2	3	4	5
FATHER:	1	2	3	4	5

B--RESOURCES

7. Who are the primary wage earners in the family?

8. Total gross income (ask primary wage earner or both if other earns 40% of total):

   a. Under 3,000
   b. 3,000 - 6,000
   c. 6,000 - 9,000
   d. 9,000 - 12,000
   e. 12,000 - 15,000
   f. 15,000 - 18,000
   g. 18,000 - 21,000
   h. 21,000 - 24,000
   i. 24,000 - 27,000
   j. 27,000 and over

9. a. Educational level attained by each parent (parent-surrogate) in the home:

   MOTHER:
   FATHER:

9. b. Occupation of each parent (parent-surrogate) in the home:

MOTHER:
FATHER:

10. Number of others in home who need to be cared for:

11. How would you describe your neighborhood:

VERY GOOD	GENERALLY GOOD	AVERAGE	GENERALLY BAD	VERY BAD
1	2	3	4	5

12. How would you describe your home?

VERY GOOD	GENERALLY GOOD	AVERAGE	GENERALLY BAD	VERY BAD
1	2	3	4	5

C--INTERVIEW PARENTS SEPARATELY (CONSENSUS)

13. How much friendship do you get from the following (ask primary caretaker):

	VERY MUCH	PRETTY MUCH	SOME	A LITTLE	NONE AT ALL
a. Husband-Boyfriend/ Wife-Girlfriend	1	2	3	4	5
b. Relatives	1	2	3	4	5
c. Neighbors/Friends	1	2	3	4	5
d. Clubs, Groups, Classes, Activities	1	2	3	4	5
e. Children	1	2	3	4	5
f. How would you describe your friendship situation?	1	2	3	4	5

14. a. How would you describe your housework and shopping situation?

	VERY GOOD	GENERALLY GOOD	AVERAGE	GENERALLY BAD	VERY BAD
MOTHER:	1	2	3	4	5
FATHER:	1	2	3	4	5

b. How would you describe the child care arrangements (e.g., babysitting availability)?

	VERY GOOD	GENERALLY GOOD	AVERAGE	GENERALLY BAD	VERY BAD
1) Babysitter	1	2	3	4	5
2) Day Care	1	2	3	4	5
3) Relative/Family	1	2	3	4	5
4) Husband-Boyfriend/ Wife-Girlfriend	1	2	3	4	5
5) Children	1	2	3	4	5
6) Neighbors/Friend	1	2	3	4	5
7) Other	1	2	3	4	5

15. Lately, how much affection do you have for your husband-boyfriend/wife-girlfriend?

	VERY MUCH	PRETTY MUCH	SOME	A LITTLE	NONE AT ALL
MOTHER:	1	2	3	4	5
FATHER:	1	2	3	4	5

16. Lately, how much affection do you have for your children?

	VERY MUCH	PRETTY MUCH	SOME	A LITTLE	NONE AT ALL
MOTHER:	1	2	3	4	5
FATHER:	1	2	3	4	5

17. How much affection do you receive from your husband-boyfriend/wife-girlfriend?

VERY MUCH	PRETTY MUCH	SOME	A LITTLE	NONE AT ALL
1	2	3	4	5

18. How much affection do you receive from your children?

VERY MUCH	PRETTY MUCH	SOME	A LITTLE	NONE AT ALL
1	2	3	4	5

19. How would you rate the physical health of your family members?

	VERY GOOD	GENERALLY GOOD	AVERAGE	GENERALLY BAD	VERY BAD
MOTHER:	1	2	3	4	5
FATHER:	1	2	3	4	5
TARGET CHILD:	1	2	3	4	5
OTHERS IN HOME:	1	2	3	4	5

20. How good is your emotional health?

	VERY GOOD	GENERALLY GOOD	AVERAGE	GENERALLY BAD	VERY BAD
MOTHER:	1	2	3	4	5
FATHER:	1	2	3	4	5

21. How many serious upsetting events have occured in the past 12 months?

D--COMMITMENT

22. What percent of your child's care do you do?

0 - 10%
11% - 20%
21% - 30%
31% - 40%
41% - 50%
51% - 60%
61% - 70%
71% - 80%
81% - 90%
91% -100%

23. About how much time per day do you spend with your child playing and teaching him/her?

MOTHER:
FATHER:

24. About how much free time do you have to do what you enjoy?

MOTHER:
FATHER:

25. In general do you find being a parent easy or difficult?

	VERY EASY	GENERALLY EASY	AVERAGE	GENERALLY DIFFICULT	VERY DIFFICULT
MOTHER:	1	2	3	4	5
FATHER:	1	2	3	4	5

26. Overall, how well do you think your child is growing?

	VERY DELAYED	PRETTY DELAYED	SOMEWHAT DELAYED	SLIGHTLY DELAYED	NOT AT ALL DELAYED
MOTHER:	1	2	3	4	5
FATHER:	1	2	3	4	5

27. What specific thing would you like to see your child begin doing in the next three months or so?

MOTHER:
FATHER:

28. How sure do you feel that your child will learn to (short term goal, #27)?

	VERY SURE	SOMEWHAT SURE	NOT TOO SURE	SOMEWHAT DOUBTFUL	VERY DOUBTFUL
MOTHER:	1	2	3	4	5
FATHER:	1	2	3	4	5

29. How important are the things that you can do to help him/her learn to (short term goal, #27)?

	VERY IMPORTANT	PRETTY IMPORTANT	SOMEWHAT IMPORTANT	NOT TOO IMPORTANT	NOT AT ALL IMPORTANT
MOTHER:	1	2	3	4	5
FATHER:	1	2	3	4	5

30. How do you feel about your child's future? (How does the future look in terms of what you would like for your child?)

	VERY GOOD	GENERALLY GOOD	AVERAGE	GENERALLY BAD	VERY BAD
MOTHER:	1	2	3	4	5
FATHER:	1	2	3	4	5

31. How would you rate your husband/wife (boyfriend/girlfriend) as a parent?

	VERY GOOD	GENERALLY GOOD	AVERAGE	GENERALLY BAD	VERY BAD
MOTHER:	1	2	3	4	5
FATHER:	1	2	3	4	5

32. How would you rate yourself as a parent?

	VERY GOOD	GENERALLY GOOD	AVERAGE	GENERALLY BAD	VERY BAD
MOTHER:	1	2	3	4	5
FATHER:	1	2	3	4	5

33. Are you interested in learning about ways of helping your child to (goal)?

	VERY INTERESTED	PRETTY INTERESTED	SOMEWHAT INTERESTED	NOT TOO INTERESTED	NOT AT ALL INTERESTED
MOTHER:	1	2	3	4	5
FATHER:	1	2	3	4	5

34. All parents have their own ideas about the best ways to raise children. How well does your husband/wife (boyfriend/girlfriend) understand your child(ren)?

	VERY WELL	PRETTY WELL	ALL RIGHT	NOT TOO WELL	NOT AT ALL
MOTHER:	1	2	3	4	5
FATHER:	1	2	3	4	5

35. How often do you disagree with the way your husband/wife (boyfriend/girlfriend) disciplines the child(ren)?

	ALWAYS AGREE	GENERALLY AGREE	HALF & HALF	GENERALLY DISAGREE	ALWAYS DISAGREE
MOTHER:	1	2	3	4	5
FATHER:	1	2	3	4	5

36. How often do you and your husband/wife (boyfriend/girlfriend) agree or disagree about sharing child care?

	ALWAYS AGREE	GENERALLY AGREE	HALF & HALF	GENERALLY DISAGREE	ALWAYS DISAGREE
MOTHER:	1	2	3	4	5
FATHER:	1	2	3	4	5

37. How often do you and your husband/wife (boyfriend/girlfriend) agree or disagree about work that has to be done around your house?

	ALWAYS AGREE	GENERALLY AGREE	HALF & HALF	GENERALLY DISAGREE	ALWAYS DISAGREE
MOTHER:	1	2	3	4	5
FATHER:	1	2	3	4	5

38. How often do you and your husband/wife (boyfriend/girlfriend) agree or disagree about how to spend free time?

	ALWAYS AGREE	GENERALLY AGREE	HALF & HALF	GENERALLY DISAGREE	ALWAYS DISAGREE
MOTHER:	1	2	3	4	5
FATHER:	1	2	3	4	5

39. How often do you agree or disagree with the way your wife/husband (girlfriend/boyfriend) spends money?

	ALWAYS AGREE	GENERALLY AGREE	HALF & HALF	GENERALLY DISAGREE	ALWAYS DISAGREE
MOTHER:	1	2	3	4	5
FATHER:	1	2	3	4	5

Appendix D

Treatment Groups

TREATMENT GROUPS

Several types of groups were used to provide services to our clients. The first group run by ISFAR staff focused on teaching parents appropriate ways of responding to their children's misbehavior. This group was limited to six sessions. It was attended by four couples. The children in four of these families has been subjected to abuse that included harsh spankings. In a number of the households the mothers were unable to control their children's misbehavior. Serious child behavior problems were evident in only one family. In this case the child had a serious hearing and speech disorder.

Initially each group member was asked to identify one child behavior that they would like to change. With the exception of the parent who had a handicapped child, all the parents identified behavior problems that are common to many children. Parents were told that they would learn some techniques for dealing with their children's misbehavior.

Each group session was structured to provide an initial ten minutes of casual conversation followed by a twenty minute presentation on a behavior management technique, a five minute role play depicting a situation that the parents had identified as problematic and a twenty to thirty minute discussion of the lesson and the role play. The conversation during this period often focused on specific problems the parents were having with their children. During this time group leaders sought to understand how the parents were handling these problems and then suggested alternatives to their present discipline strategies. The meetings ended after a brief period of socializing. Role playing proved to be a very useful way for the group leaders to demonstrate both desirable and undesirable behavior management practices. The presentations by the group leaders left members free to be critical of examples of inappropriate child care techniques where they might not have felt so free to criticize had the role play been done by other parents.

The follow-up of what parents learned in group was provided during home visits by the Family Workers. The workers helped the parents adapt what they had heard at the group to their home situation. A combination of general presentation of principles and techniques coupled with discussion and followed by home visits proved to be fairly successful.

The group also had some other benefits. A number of fathers who had only limited involvement with their children became much more involved after the male group leader urged them to help their wives learn to manage their children's behavior. The fathers and mothers were also told that fathers play a vital role in their children's development. As a result several fathers and mothers revised their ideas about the ways fathers can be involved with their children and the kinds of help they can offer their wives.

We found that this group provided an excellent forum for teaching behavior management to parents. In several households the group stimulated role changes that allowed information obtained in the group to be used by both parents in a cooperative fashion. Parent reports indicated that several of them found that the group allowed them to work with their children and to reduce their children's behavior problems using less punitive strategies than they had previously relied upon.

The purpose of another group was to provide socialization and help with learning to solve problems to several young, isolated mothers. This group met for more than a year. It was regularly attended by a group of five mothers and by three other mothers who attended sporadically. The group met for about ninety minutes. A talk by the group leader or a guest speaker lasted for the first thirty minutes. Group discussions of the presentation and of possible solutions to problems members presented took the remaining hour.

The group accomplished a number of important tasks. The meetings were effective in reducing some of the isolation of these mothers. In fact, several of the groups' members became friends and began to interact apart from the group. The group supported the efforts of two of the mothers to find employment. Group members also provided one another with helpful ideas about how to solve resource and child behavior problems.

For the project a major advantage of the group was that it reduced the need for workers to have more time consuming and costly individual contacts with these clients. For the most competent mothers it was possible to eliminate routine individual visit entirely because both mothers and children were seen regularly at the time the group met.

Two groups were developed for a number of ISFAR mothers who were retarded and for their preschool aged children. Both groups were initiated because these mothers and children had few playful interactions and because several of the mothers needed guidance on how to stimulate their children's development. The first group was a play and discussion group. Both parents and children participated in this group. The goals of the group were to: 1) provide opportunities for mothers and children to have fun together; 2) to present parenting information and situations in which parents could practice what they learned with their children; and 3) to provide a pleasant situation in which the parents could socialize.

The group was structured to begin with a period of socialization followed by a period of instruction and guidance after which there was play with the children. The group ended with refreshments for everyone. The content of group sessions ranged from topics on child- proofing a room to personal grooming. During the parent-child play times, toys were introduced to the mothers, and they were encouraged to present these to the children. The content of these group sessions was geared to the parents' learning styles. The information presented was specific; parents were given opportunities to see demonstrations and to practice techniques under supervision.

A swim group was also available for these mothers and their children. This group was held weekly for five weeks. The objective of this group, like the other, was to encourage enjoyable interaction between parents and children and to teach parents how to respond appropriately to their children' s moods and interests. This group was possible because one of the family workers was a Certified Water Safety Instructor and had experience with family swimming activities. In the group, parents were encouraged to be responsive to their children's feelings as they helped the children overcome fear of the water. Parents were also taught water safety. Each mother learned how to hold her child while they were in the water. Parents also learned to supervise their children's play in the water. As a result of the group, a number of children learned to do a swimming kick and had the opportunity to play in the water under the supervision of their parents and ISFAR staff members. For both groups, these parent-child group meetings provided workers with opportunities to see how the parents responded to their frustrations when their children failed to do what their parents wanted. When problems arose, workers were able to demonstrate procedures for reducing parent-child conflict.

Appendix E

Staffing Plans

STAFFING PLAN

1. Identifying information:
    - a. Name:
    - b. Birthdate:
    - c. Residence (type and location):
    - d. Race:
    - e. Members of household:

2. Reason for referral:

3. Child's developmental status:

4. Medical and dental information:

5. Parents' perceptions of child's developmental level, accuracy of perceptions:

6. Parents' affect, quality of thought, quality of judgement:

7. Locus of control:

8. Social history, family history:

9. Commitment - a) interview measure:

    b) staff observations of commitment to child's care and development:

10. Resources:
- a) number of people available to help mother with child care:
  household chores:
- b) income:
- c) physical health:
- d) emotional health
- e) extended family
- f) mobility
- g) supportive relationships:

11. Concensus:
- a) agreement of significant persons on problems in family and their solutions:
- b) agreement on divisions of labor:

12. Boundaries:
- a) agencies involved with family:
- b) what purpose do they serve:
- c) to what extent are they interfering with the families ability to make their own decisions:

Personal boundaries
- a) enmeshed, symbiotic, or isolated:

13. Parent Child Care Skills:

Restaffing

1. Entry Information
    - A. Employment history
    - B. Educational level
    - C. Family History

      abuse and/or neglected as a child

      early parenthood
    - D. Marriage Problems
    - E. Characteristics - check those which apply
        1. poor self image
        2. low impulse control
        3. no telephone
        4. no means of transportation
        5. target child premature
        6. unwanted pregnancy
        7. alcohol
        8. drug abuse
        9. obvious mental health problems
        10. obvious health problems
        11. financial problems
    - F. Response to CPS Entry
    - G. How Long Before Client Defined Problem
    - H. First Problem defined and Worked On
        1. Child related
        2. Personal
        3. Marital
        4. Resources

5. Intrapersonal

I. Check Appropriate Level on Problem Solving Skills

1. can identify problem

2. can get information needed to solve problem

3. can identify options

4. can solve problem

J. How Many Moves

K. Where does Worker Identify Problems

1. child related

2. personal

3. marital

4. resources

5. intrapersonal

L. Had There Been Previous CPS Referrals (was CPS contact helpful to the family)

M. Had There Been Previous Removals

N. How Many Social Agencies or Helpers Were Involved and Who

O. How Quickly Did You Expect This Family to Change

P. What Areas Did You Believe Change Would Occur in First

II. Process

A. Review Points

1-3 months	1. What kinds of problems were defined.
	2. What kinds of changes happened.
	3. How often were you in contact with the family
3-6 months	1. What kinds of problems were defined
	2. What kinds of changes happened
	3. How often were you in contact with the family

6-9 months Same questions

9-12 months Same questions

12-15 months Same questions

15-18 months Same questions

18 months to present

B. Worker

1. Did the client have a change of worker at any time during this period?
2. What effect if any was seen with this change?
3. Did Client seem to avoid worker at any time during this period?

C. Changes - check the following areas and indicate how much or often

1. Jobs
2. Schools
3. Reports to CPS
4. Unwanted Pregnancies
5. Trips to Emergency Room
6. Run out of food, rent money
7. Housing/home environment
8. Change in interaction with child
    - A. measure by Caldwell
    - B. observed by worker
    - C. observed by other
    - D. mentioned by client
9. Change in number of friends
10. Telephone
11. Change in marital relationship

12. Change in self-image

13. Change in problem solving skills

14. Change in reason for referral

15. Will this change be maintained

16. What kind of on-going support is needed?

Appendix F

Dissemination Activities

DISSEMINATION ACTIVITIES

Throughout the three years of the project we have been sharing information with others in workshops, conferences and round-table discussions. As the project is drawing to an end, these activities have increased.

Presentations, 1978 - Local:

1. Presentation to the ISFAR Advisory Group, Omaha, Nebraska, April 1978.
2. Dealing with Families who Abuse their Children - Child care staff - Omaha Housing Authority, Omaha, Nebraska, June 1978.
3. "Working with Neglecting Families" - University of Nebraska Child Welfare Class, Omaha, Nebraska, November 1978.

Presentations, 1979 - Local and State:

1. "Profile of an Abusing Family" - Head Start staff, Omaha, Nebraska, April, 1979.
2. "Effects of Abuse and Neglect on Children," Symposium Early Childhood Education, Nebraska Psychiatric Institute, Omaha, April 1979.
3. "Working with Involuntary Clients," Child Abuse Council of Omaha, April 1979.
4. Working with Abusing and Neglecting Families," in staff training, Eastern Nebraska Human Services Agency, May 1979.
5. "Abusive Families," Nebraska Association of Counselors, Lincoln, Nebraska, September 1979.
6. "Services for Families," Inservice training for residents at Creighton University Medical School, October 1979.

National:

1. "Assessment and Planning of In-Home Services," Second Annual Symposium on In-Home Services, Iowa City, Iowa April 1979.
2. "Assessment and treatment planning for in-home services: Two approaches to family assessment," Annual meeting of the American Association of Psychiatric Services for Children, Chicago, Illinois, November 1979.
3. "Enhancement of Parental Attachment and Child Care Skills in At-Risk Foster Placement Families," Annual meeting of the Americian Association of Psychiatric Services for Children, Chicago, Ill., November 1979.
4. "Services to Child Protection Families," Region VII Child Welfare Program Committee meeting, Kansas City, Missouri, December, 1979.

1980 Presentations - Local and State:

1. "Family Stress and Incest," Girls Club staff and program participants, Omaha, Nebraska, April and November 1980.
2. "Abuse and Neglect," KESY, Broadcast, Profile of Problems, Omaha, Nebraska, April 1980.
3. "Abuse and Neglect," KIOS Radio Broadcast, Issues of Concern - Problem, Omaha, Nebraska, April 1980.
4. "Working with Developmentally Disabled Parents," Child Abuse Council of Omaha, May 1980.
5. "Chronic Client," Family Services of Omaha - Council Bluffs, May 1980.
6. "In Home Services," Department of Public Welfare staff, Lincoln, Nebraska, July 1980.

7. "ISFAR Project," KFAB Radio Broadcast, Health Issues - Problems, Omaha, Nebraska July 1980.
8 "Initial Findings - ISFAR," Nebraska County Welfare Director's Meeting, York, Nebraska, September 1980.
9. "Assessment for Protective Services," Fall Social Work Workshop, Lincoln, Nebraska, October 1980.
10. "Research in Child Abuse," UNO School of Social Work, class on research, Omaha, Nebraska, November 1980.
11. "Abuse and Neglect," Joni Ballion Show, Omaha, Nebraska, November 1980.
12. "Stresses in Parenting," Conference for Family Life Educators, Creighton University, Omaha, Nebraska, 1980.

National:

1. "The Curriculum Content for Specialization in Child Welfare," Region VII Dissemination meeting in Social Work Education in Child Welfare, Kansas City, Missouri, April 1980.
2. "The Child Welfare Practicum," Region VII Dissemination meeting in Social Work Education in Child Welfare, April 1980.
3. "Working with Involuntary Clients," Child Welfare League, Des Moines, Iowa, May 1980.

On-Going Training, 1980:

Planned and delivered initial and ongoing training for Parent Assistance Line Volunteers, Omaha, 1980, 1981.

Developed curriculum and taught 8 week course, "Working with Abusive and Neglectful Families," School of Social Work, University of Nebraska at Omaha, Omaha, Nebraska 1980-81.

Presentations 1981 - Local and State

1. "Assessment and Case Planning," Child welfare workers. Department of Public Welfare, Lincoln, Nebraska, February 1981.
2. "Working with Multi-problem Families," University of Nebraska at Omaha School of Social Work, 1981.

National:

1. "Possibilities for Change: The Intellectually Handicapped Parent," Fifth National Conference on Child Abuse and Neglect, Milwaukee, Wisconsin, April 1981.
2. "The Intellectually Limited Parent," NASW National Symposium, Philadelphia, Pennsylvania. November 1981.
3. "Working with Neglecting Families," American Orthopsychiatric Association Meeting, San Francisco, California, March 1982.
4. "Network Foster Placement for Children," American Orthopsychiatric Association Meeting, San Francisco, California, March 1982.

Publications:

1. Rosenberg, S.A., Robinson, C.C., and McTate, G.A., "Assessment and planning of in-home services," In Bryce M. & Lloyd, J. (Eds.), Home Based Services for Families, Springfield, Ill., C. Thomas, 1980.
2. Rosenberg, S.A., & McTate, G.A., "The intellectually limited parent: Problems and prospects," Children Today, 1982,11, 24-37.

Future Dissemination Plans:

Future plans include a presentation to the Director of the Department of Public Welfare, Lincoln, Nebraska, not yet scheduled and submission of three in progress papers for publication, papers concerning the chronic client, social network foster placements.

A videotape on intellectually limited parents is now in production. Materials developed by ISFAR are now being incorporated into the Child Welfare Curriculum for Social Work at the University of Nebraska - Omaha, and into the training of child welfare workers by the Nebraska Department of Public Welfare.